THE RESISTANCE OF AN ESTABLISHED PROFESSION TOWARDS AN EMERGENT OCCUPATION

by

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Abstract

This study examines the relationship between orthopaedic and podiatric surgeons which has formed since the NHS reforms of the 1990s facilitated the establishment of podiatric surgery as a mainstream health-care service. Relations between these two disciplines are considered against the traditional background of dominance of health-care by the medical profession. The study seeks to understand the resistance shown towards podiatric surgery by orthopaedic surgeons and to determine if there is a willingness among orthopaedic and podiatric surgeons, respectively, to develop a more satisfactory working relationship.

Two methods of data collection were employed to gather information on the views of orthopaedic surgeons on podiatric surgery. Firstly, questionnaires were sent to all Fellows of the British Orthopaedic Association with the intention to collect a breadth of data. In this way a total population was contacted by means of the survey. Secondly, personal interviews were undertaken with fifty orthopaedic surgeons who indicated a willingness to take part in their questionnaire responses. These interviews were designed to add richness and depth to the data gathered from the questionnaires. All podiatric surgeons in the UK were also sent questionnaires in order to investigate their professional experiences with, and their attitudes towards, orthopaedic surgeons. Once again, a total population was surveyed.

A range of attitudes towards podiatric surgery was found among orthopaedic surgeons but significant opposition was identified. Reasons for this opposition are multi-factorial and complex. Overall, there appears to be an imperative to maintain control and, therefore, medical dominance over a competing occupation. For some orthopaedic surgeons, this control is perceived as necessary if the prestige and status of

orthopaedic surgeons are to be protected. For others, collaboration with podiatric surgeons is a possibility although many orthopaedic surgeons have reservations about a formal union which often result from a lack of understanding about many aspects of podiatric surgery.

Podiatric surgeons are generally in favour of developing closer links with orthopaedic surgeons, though they have concerns about a possible loss of autonomy arising from any collaboration. The development of a closer working relationship between orthopaedic and podiatric surgeons could have benefits for health-care but it seems likely that this may only occur on a gradual basis and through negotiations conducted at local levels.

Contents

Tables

Illustrations

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Glossary of Abbreviations

BCJ	British Chiropody Journal
BJC	British Journal of Chiropody
BMA	British Medical Association
BOA	British Orthopaedic Association
BRMA	Board of Registration of Medical Auxiliaries
COPSS	Commission on the Provision of Surgical Services
CPSM	Council for the Professions Supplementary to Medicine
GMC	General Medical Council
HPC	Health Professions Council
PSM	Professions Supplementary to Medicine
RCS	Royal College of Surgeons
SOCP	Society of Chiropodists and Podiatrists

AUTHOR'S DECLARATION

At no time during the registration for the degree of Doctor of Philosophy has the author been registered for any other University award without prior agreement of the Graduate Committee.

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Chapter 1
Introduction

In this first chapter I introduce my research by describing how the medical profession has always successfully dealt with challenges to its dominant position in health-care from other occupations. I continue by explaining the concept of a podiatric surgeon and how podiatric surgery has evolved to the extent that it now offers serious competition to orthopaedic surgery in the provision of foot surgery services in the NHS. I describe the circumstances which have facilitated the establishment of podiatric surgery within the NHS and explain that this development has led to conflict between the orthopaedic and podiatric disciplines.

Having presented the historical background to my study, I go on to review the relevant sociological literature. My rationale for undertaking this research follows and I divide this into professional and personal perspectives. In the former, I outline the aims of the project and also the benefits that I hope may result from the study. In the latter perspective I discuss events which acted as a stimulus for me to embark on this investigation. In keeping with this personal reflection, I comment on adjustments to my presentation and writing style I had to make in response to the requirements of this dissertation. I conclude by detailing the contents of the chapters which follow.

1.1 Background to the study

The hegemonic position of the medical profession in the division of labour in health-care is widely recognised (Coburn and Willis, 2000; Borthwick and Dowd, 2004). The concept of medicine as the dominant profession has existed from the time clearly demarcated forms of occupation within health-care became evident. Ever since the Medical Registration Act of 1858 provided the autonomy to determine the content of medical practice and how it should

be carried out (Moran, 1999), the medical profession has endeavoured to protect itself from outside influence and has claimed and maintained control, to a greater or lesser extent, over other occupations involved in health-care. Willis (1994) discusses the power of the medical profession and talks of its autonomy, authority, and medical sovereignty. Autonomy is the power to control the profession's own work while authority means that doctors are able to direct the activities of other health-care occupations and in medical sovereignty, as Willis observes, the profession regards itself as the expert in all matters relating to health.

In order to maintain this position of dominance the medical profession has needed to exclude, limit, or subordinate other occupations (Willis, 1989). Examples of these strategies can be found in chiropractic, optometry and nursing respectively. The medical profession has found this possible because it has enjoyed what Abbott (1988) terms a full jurisdiction over sickness. This claim has been established and approved in the public and legal arenas. In the public domain, approval for a jurisdictional claim is usually sought by persuading the public that the claimant is the only one capable of interpreting and applying an esoteric body of knowledge. A successful public claim will facilitate attempts to gain a legal jurisdiction. The importance to a profession's power of securing this legal mandate is stressed by several writers (Freidson, 1970, Willis, 1989).

Medicine has preserved its hierarchical status despite various challenges from a variety of sources. Larkin (1983) questions Freidson's (1970) use of the term 'professional dominance' because he argues that it implies 'zero-sum conflict' whereas the division of labour is an on-going struggle for control of occupational territories. As early as 1902 the Midwives Act served to challenge medical control. Although midwives remained subordinate to medicine, the Act did give them recognition and a certain status which medicine had sought to deny. The Nurses Act (1919) and the Dentists Act (1921) also brought recognition and regulation to other health-care occupations without significantly

eroding the power of medicine. However these Acts did serve to alert the medical profession to the 'danger of dilution, fragmentation and decline' if any more such legislation was enacted (Larkin, 2002:123). As a result, when that collection of occupations known as professions supplementary (or allied) to medicine (hereafter referred to as paramedical occupations) began to agitate for formal state recognition, the medical profession actively sought to resist this. Larkin (1983, 2002) has comprehensively described the struggle of these occupations to gain state registration. For some occupations, like chiropody, achieving this aim took almost half a century but their persistence finally culminated in the Professions Supplementary to Medicine Act 1960. Medicine had always been dependent on the state in its efforts to control other health-care occupations. The passing of the 1960 Act, and on the conditions it imposed, represented something of a rebuke to the medical profession because it reduced medical control over paramedical occupations by adding a more formal expression of state authority (Larkin, 2002). As such it signified that state alliance was not something to be taken for granted. Larkin (1983), however, does not view this development as removing medicine's control over these occupations but sees it more as a case of preserving control within a framework of statutory legislation. Whether this assertion is accurate with regard to the other paramedical occupations is beyond the scope of this dissertation but, in the case of chiropody (podiatry), developments in scope of practice since gaining state registration mean that Larkin's view now needs reassessment. Before outlining these developments, the nature of other challenges to medicine's power over the health-care arena should be noted.

An overview of modern challenges to medicine is provided by Kelleher et al, (1994). Internal to health-care, the occupational development of nursing has resulted in the creation of such hybrids as the 'nurse-practitioner' and may be viewed as a measure

designed to gain greater autonomy from doctors. Alternative medicine, in its various forms, presents another challenge, albeit outside the orthodox health-care environment. External to health-care, the rise in the litigation culture means that lawyers are increasingly challenging the authority of the medical profession (Dingwall, 1994). The media play their part when presenting a narrow journalistic perspective which criticises medicine and encourages the public to question the confidence they have traditionally invested in doctors. Lay people are more inclined today not to accept Willis' 'sovereignty' of the medical profession and undertake their own health-care research. Feminists have shown a determination to investigate links between capitalist and patriarchal organisations in society and to improve working and living conditions which impact on women's health (Kelleher et al, 1994).

Whilst all these sources represent significant challenges in their own right, the most striking attempts to reduce the power of the medical profession have come from the state itself. In the 'golden age' of the profession in the mid-twentieth century, doctors were seen as 'exemplary members of a professional society' (Perkin, 1989 cited in Kelleher et al, 1994). Since that time, however, there have been growing concerns about a misuse of power, that the medical profession has come to serve its own ends rather than existing to meet the needs of society. Wilsford also noted a transnational 'confrontation of scarce resources to pay health care with a rising demand for technical capacity to provide care' (Wilsford, 1991:3). These concerns regarding the medical profession, which pre-date Wilsford, resulted in government reforms of the NHS in the 1970s, 80s, and 90s which are considered in greater depth later in this dissertation. The objective of these reforms was to make the NHS more cost-effective at the same time as reducing the power of medicine, particularly as it related to hospital consultants. The 1990s reforms were particularly radical; a competitive internal market was introduced based on a purchaser/provider split

which was intended to make health professionals more accountable. Consumerism was highlighted within the philosophy behind these reforms and the public was given 'new' rights under a Patient's Charter. These reforms impacted on hospital consultants in a far greater way than the reforms of the 1970s and 80s had done. With regard to consultants in the speciality of orthopaedic surgery the combination of these reforms and challenges from the various sources outlined above, meant there was some utility of the so-called proletarianization and deprofessionalisation theories (also discussed later). According to Light (1995), in the period from 1980 to 1992 UK consultants had moved from a position of being state employed but enjoying high levels of professional domination to a position of being state employed but enduring a slight degree of state domination. They had moved from 'protected professionalism to contracted professionalism, from autonomy and authority to accountability and performance with managers in a pivotal middle position' (Light, 1995:31). The net result is that hospital consultants, including those in orthopaedic surgery, were placed under considerable professional pressure. It was around this time, facilitated by the 1990s NHS reforms, that a speciality which had evolved from a paramedical occupation – podiatric surgery – emerged to challenge the dominance of orthopaedic surgeons in the provision of foot surgery in the NHS.

Podiatric surgeons are podiatrists, formerly called chiropodists, who have gone on to undertake advanced and extensive training in order to qualify as surgeons. As a speciality, podiatric surgery has its origins in the USA in the 1960s. During the late 60s and early 70s British chiropodists visited the States and learned new techniques from the rapidly evolving American podiatrists. On returning to England these chiropodists started to employ their newly-learned techniques in their private practices and their success stimulated interest amongst their peers who were eager to advance their scope of practice.

American podiatrists visited Britain and taught podiatric techniques to ever-increasing groups of eager-to-learn chiropodists (Borthwick, 2005).

From these beginnings podiatric surgery started to become established in the private practice environment in Britain. In the 1970s an official organisation – the Podiatry Association – was formed for those practitioners wishing to embrace surgical techniques. This Association came to rival the existing pre-eminent body – the Society of Chiropodists – as a national membership organisation for chiropodists/podiatrists. Members performing foot surgery started to adopt the term 'podiatrist'. Podiatric surgery was, at first, performed entirely in private practice but in the 1980s it started to appear in a modest form in certain NHS districts. However, this almost imperceptible presence was boosted by the radical 1990s reforms. Podiatric surgery fitted the profile sought by NHS managers charged with extracting the most from their budgets; it was cost-effective, it could, by that time, point to a proven track-record, and, furthermore, it served as a means of reducing the authority of a section of hospital consultants.

To arrive at a position where it directly challenged medicine, or at least one faction of it, was a radical departure for podiatrists who, as chiropodists, had traditionally always been subservient to the medical profession. As the later chapter on the development of podiatry will show, the discipline was led, for the greater part of the twentieth century, by officials who believed that the best chances for social advancement lay in adopting a policy of appeasement, of subservience, to the medical profession. It was not until the passing of the PSM Act 1960 which arguably removed medical control, if not influence, over the occupation that members emerged who were willing to exploit opportunities, or 'loopholes', in statutory regulations to increase their scope of practice, and thereby incur the disapproval of the medical profession. It was from these early seeds of endeavour that

the podiatrist's scope of practice grew and opened the way for the emergence of podiatric surgery.

As might be expected, the appearance of podiatric surgery as a NHS service was not greeted with universal acclaim amongst orthopaedic surgeons. The scene was thus set for another challenge to medical power, but why do such challenges come about? Light (1995) contends they arise because dominance can lead to forms of excess, that is, excesses can occur when there is no effective opposition to temper the behaviour of the dominant force. Provoked by the results of such excesses, other actors who are contextually involved will seek to redress the injustice they perceive these excesses to represent. Light describes possible forms of excess and three of these are applicable to the current study: firstly, with dominance there is a tendency to consume more and more of the nation's wealth. Clearly this was one factor which prompted the1990s reforms and, more significantly, it predisposed health-care purchasers to consider podiatric surgery favourably. Secondly, medical dominance tends to involve a self importance that may lead to neglect of the interests of clients and institutional partners. Again this is recognised as one of the concerns which led to the Health Service reforms and also stands as a factor likely to aggravate the first form of excess above. Of particular relevance to podiatric surgery is the client care issue. A firm conviction amongst podiatric surgeons is that orthopaedic surgery of the foot can be poorly performed, hence the need for the podiatric surgeon. As one podiatric respondent would later comment during the research for this study "If orthopaedic surgery is so good, why is there podiatric surgery?". Finally, an excess of authority can affect the degree and nature of competition with adjacent professions. Essentially, with medical dominance, competition was not allowed, that is, the medical profession has always sought to subordinate, or at least limit, adjacent professions before competition could arise. But podiatric surgery would represent perceived competition and lead to conflict when its

discrete area of work (although following a different philosophy and employing different techniques) could not be completely separated from that of the orthopaedic surgeon.

When such excesses occur the way is opened for an alliance of 'countervailing powers' (Light, 1995; Hartley, 2002). In this framework two or more parties with common interests join up and countermobilise to redress the imbalances produced by the domination of a third party. Countervailing powers, in the context of this dominance by orthopaedic surgeons, were the podiatric surgery discipline itself and the purchasing or commissioning agents of the NHS. The latter were represented by Health Service managers who, as already discussed, were seeking value for their money and control of hospital specialists, and GP Fundholders who, in addition to also looking for economical value, may sometimes have met with orthopaedics self-regard.

That conflict has resulted, and persisted, is not in doubt (Borthwick, 2004). That it occurred in the first place, because orthopaedics could not subordinate podiatric surgery, is due to a reduction in the public mandate that orthopaedics once enjoyed, and the weaknesses of its legal mandate. Until the emergence of podiatric surgery the public had no alternative in the provision of foot surgery. It was forced to grant orthopaedic surgery autonomy in return for promises of altruism and quality and trust that those promises would be kept (Light, 1995). But once podiatric surgery offered an alternative method of treatment that autonomy, in the area of foot surgery, was thrown into doubt. If the public did not withdraw orthopaedic surgery's mandate it certainly took away its exclusivity. In terms of the medical profession's legal mandate, there was nothing to prevent podiatric surgeons from offering the service they provided. On application to the Privy Council, the Royal College of Surgeons (RCS) found their Royal Charter only gave them the right to regulate their own members. Abbot (1988) comments that it is rare for a dominant profession to hold workplace jurisdiction over others without any sort of legal protection.

But podiatric surgery has successfully challenged orthopaedic surgery largely because there was no legal impediment to it doing so. In other words, the full jurisdictional settlement described by Abbott and enjoyed by the medical profession was never based on a 'watertight' legal foundation. The state arguably has failed orthopaedic surgery twice, once by not providing it with full legal protection, and, secondly, because its agent, the NHS, effectively encouraged a challenge from a competing discipline.

Podiatric surgery has gone on to establish a relatively small but significant presence in the NHS. This process has not been an easy one. Orthopaedic surgery has attempted to resist its establishment ever since its early appearance in the NHS in the late 1980s. Anecdotally there have been tales of attempts at obstruction by orthopaedics ever since podiatric surgery first appeared in the UK. At one time levels of opposition became sufficiently high to prompt the British Orthopaedic Association (BOA) to issue a warning to its membership that such behaviour was unacceptable (BOA, 1995). Concern at the progress of podiatric surgery was probably one reason behind a Royal College of Surgeons sponsored inquiry in the early 1990s which was ostensibly intended to improve working practices amongst those involved in the provision of foot surgery (orthopaedic and podiatric surgeons). Much of this resistance towards podiatric surgery, though, remains anecdotal and its extent unqualified. However, if, indeed, opposition is at a significant level, what are the reasons behind it? Is it simply resentment that orthopaedic surgeons must face some form of competition or are the reasons deeper and more complex?

1.2 Previous work

Until recently podiatry has seldom featured in sociological literature. Larkin (1983) devoted an entire chapter to the discipline (then known as chiropody), tracing development in the period from the early twentieth century to 1960 when state registration was secured.

His focus was partly on organisational strategies but more specifically on relations between health-care professions and the state. His later contributions to the literature (1995, 2002) have dealt with the paramedical occupations without special consideration of podiatry.

Over the last few years Borthwick has proficiently added to the literature examining the profession. His informative 1997 thesis dealt with the professionalisation strategies of British podiatry and provided the impetus for a series of articles which added detail to my account of the development of podiatry and which are referenced in the appropriate chapter. Two articles have considered podiatric surgery. His 1999 paper, 'Challenging medical dominance: podiatric surgery in the National Health Service', essentially charted the development of podiatric surgery and its gain of a foothold in the NHS of the 1990s; interprofessional conflict was discussed from the position of the representative bodies but the roles of individual practitioners were not explored. In 2004 Borthwick's collaboration with Dowd, 'Medical dominance or collaborative partnership? Orthopaedic views on podiatric surgery' was published. Here ten semi-structured interviews with orthopaedic surgeons provided the basis for an assessment of 'grass-roots' opinions towards podiatric surgery. Set against a background of government rhetoric advocating multi-disciplinary collaboration, this research sought to establish if there was a true willingness to countenance a working partnership with podiatric surgeons. The authors admit the study was limited through the small number of interviews on which it was based. Nevertheless some of the findings accurately reflect the results of the current, more extensive investigation.

But my criticism of Borthwick and Dowd's contribution is three-fold. Firstly, their findings are based solely on a sample of ten interviews taken from a total population of over 1600. In addition the views expressed are not quantified across the ten interviews. As a result it is difficult to know how accurately the results may reflect attitudes in the total

population. Secondly, the views obtained are accepted at face-value, that is, they are taken to reflect attitudes without consideration of whether they result from any hidden agenda. Finally, although the study explicitly seeks to determine orthopaedic views, the premise on which the interviews are based is that collaboration is required by the government. Therefore, a full investigation should also consider whether collaboration is agreeable to the other party – podiatric surgeons.

1.3 Rationale for the study

The professional perspective

I have explained that there is little sociological literature regarding podiatric surgery. Borthwick's work in this area is partly a historical commentary and partly what he and Dowd call a 'snapshot' of the views of orthopaedic surgeons. The current research project aims to explore the area of interprofessional conflict between orthopaedic and podiatric surgeons in depth. Firstly, it is accepted that conflict does exist; Borthwick and Dowd (2004) confirmed this but there is also evidence in various correspondence between the professional bodies, in statements from the BOA issued to their membership, and in editorials in the journals of the medical profession. But how widespread is the conflict and what form does resistance towards podiatric surgery from orthopaedic surgeons take? Secondly, have podiatric surgeons successfully dealt with this opposition and if so, how? Thirdly, what are the reasons behind resistance? If one were to ask this of an individual orthopaedic surgeon he/she may well reactively and instinctively fire off a variety of responses. But would those reasons given be representative of all orthopaedic surgeons? Indeed, how many orthopaedic surgeons have analysed their own feelings of hostility towards podiatric surgeons? It was hoped that the current study could look behind face-value opinions by collecting a large quantity of data, some of which could be crosstabulated

in order to explore links between attitudes, and then expand on possible findings by adding depth and elaboration from data acquired from personal interviews. The intention, then, was to be able to explain attitudes amongst orthopaedic surgeons with some confidence.

Finally, at the stage of writing my research proposal, a supervisor asked me what I hoped to achieve with my study. His argument was that knowledge for knowledge sake has value but there is much greater merit in research that aims to help, or to provide solutions. In the current context I would hope that my findings could improve, at least in some modest way, relations between orthopaedic and podiatric surgeons; if they actually facilitated the formation of a better working relationship that would be commendable. This dissertation does largely portray the orthopaedic surgeon as 'the villain'. In many respects this is inevitable because hostility in the orthopaedic-podiatric relationship has largely come from orthopaedic surgeons. Orthopaedics is, after all, the dominant group and have much more power to impose in this area of conflict than do podiatric surgeons. There is also, instinctively, more sympathy for a small group who quietly seek to extend the boundaries of their work than for a larger and more powerful group who overtly seek to restrain them. This impression, however, is unfortunate. Orthopaedic surgeons are individuals of great expertise and experience; they have worked hard to acquire their considerable skills and the net result of their labours is that the quality of life for many is improved. Podiatric surgeons also have expertise and work with a similar service orientation; they seek to improve society's mobility and comfort. With two disciplines who both have the ability and the desire to benefit society it is unfortunate that conflict prevents them from fully exploiting the potential to provide a comprehensive service to the public. If this study, in any way, improves this situation it will prove to have merit.

The personal perspective: what brought me to this study

Why does anyone undertake a PhD? The usual reasons given are probably that there is a desire to extend one's education, to be academically 'stretched', to increase the breadth of one's outlook, and to add to the body of knowledge in any given subject. For me these claims all have some utility but in my case there was a great interest in my subject which had formed as a result of many years spent in professional practice.

When I obtained my first professional qualification it was as a state registered chiropodist, a diploma qualification, and I was aged 22. I immediately went to work in the NHS and, from time to time, came into direct contact with doctors of whom I was almost in awe. Perhaps this was the result of indoctrination during my three-year diploma course. I remember a lecturer once telling me that, in health-care, chiropodists were regarded as the 'lowest of the low'. Or perhaps it had something to do with only holding a diploma as qualification, or perhaps it was due to my age. Whatever the reason, I definitely felt inferior to doctors.

I progressed into working in private practice, gained a teaching qualification and eventually secured a post as a college lecturer teaching chiropody. In this situation I continued to have contact with doctors but these were more likely to be consultants who I would occasionally contract to provide guest lectures on our course. In my early years as a lecturer I remember feeling uncomfortable in the company of consultants, even to the extent of carefully monitoring my speech. Over the years I gained a first degree, an additional teaching qualification, and eventually qualified as a surgeon. By this time I was sixteen years older than when I first became a state registered chiropodist. Being older, having more credible qualifications, and blessed with rather more experience of life I was

considerably more confident. In addition I was now more experienced in dealing with doctors and had come to realise they are human, they are not infallible.

My early years as a practising surgeon were not entirely comfortable as I was inexperienced and still very much on a learning curve. However, I was happier in my dealings with doctors, particularly GPs with whom I was in regular contact, and, in some cases, even came, rightly or wrongly, to sometimes enjoy a feeling of superiority. As my volume of surgery increased my interaction with orthopaedic surgeons also increased. I explain later in this dissertation that the contact I experienced was not always positive. Even more than unsatisfactory personal interaction I was sometimes subject to unpleasantness by way of third parties. For instance, a GP once informed me he had been instructed by an orthopaedic surgeon not to refer me patients. Like many of my peers I came to regard orthopaedic surgeons with a certain suspicion. In some respects I had gone 'full-circle'; from doubts and discomfort with regard to doctors on my initial qualification I had progressed to full confidence and being at ease in their company. I was now back in a position of having doubts and discomfort, albeit with regard to just one section of the medical profession.

Having come to regard doctors as highly knowledgeable but fallible human beings who can be encouraging, helpful, and supportive, I wondered why some should assume a superior attitude and be defensive and obstructive. What reasons would account for these extreme attitudes? These questions intrigued me and I was stimulated to investigate this area in search of answers. Nothing less than a full research project was likely to be sufficient to adequately address these questions.

1.4 A final word: The 'I' in research

In keeping with the personal perspective, I now turn to an issue which arose when conducting my research but which was highlighted when writing this dissertation. Throughout the following account readers will observe the frequent use of the first person, 'I', when describing both actions and thought processes involved in the collection of data and their subsequent interpretation. This was not an approach which came naturally to me. With a background in the natural sciences I had been used to writing in a detached 'objective' manner, exemplified by the use of the third person when describing the work of myself as a researcher. Consistent with this objective approach was an emphasis on discussing issues with an empirical base, those which could be substantiated by the use of references. In such circumstances it is inappropriate to introduce subjectivity until, perhaps, the discussion stage of the research report. When my early drafts of chapters began to take shape my supervisors encouraged me to abandon this approach in favour of one which placed me at the centre of the research process. I was advised to explain my own analysis of the obstacles and triumphs I experienced during the research process and not to be reluctant to bring an element of subjectivity into this analysis. This approach is advocated by Plummer (1983:136) who bemoans:

> research reports (that) have often been written as if they had been executed by machines: not a hint of the ethical, political and personal problems which routinely confront the human researcher .....

Plummer goes on to explain that the researcher is not simply a conduit for the discovery of knowledge; he or she is also a 'constructor of knowledge'. It is therefore vital that the researcher provides evidence of his or her own personal and social worlds in order for one to understand how such constructions are made. Such an auto/biographical approach is now widely advocated (Ellis, 1991, 1995, 1999; Frank, 1991, 1995; Ellis and Bochner, 2000; Anderson, 2001: Bochner and Ellis, 2002; Letherby, 2003; Katz Rothman 2007) and is

discussed in more detail in Chapter 5. But this approach does have its critics, among them one of my original supervisors (Payne, 2007). While I did not find it easy to adopt a personal style when it came to writing the dissertation, I was helped by one of my supervisors who provided copies of two papers she had written using an auto/biographical and, more specifically, an auto/ethnographic approach (Ettorre 2005, 2006). I learned from this and as a result the following account is, hopefully, written with greater subjectivity; I also hope it conveys to the reader some of the emotional highs and lows I experienced during the research process.

1.5 The dissertation

Following this introductory chapter, Chapter 2 provides an overview of how medicine has come to be the dominant profession in health-care. It is important to understand this historical background if the orthopaedic-podiatric conflict is to be viewed in an appropriate context. Key moments in the development of the medical profession are noted leading to the mid-twentieth century when medicine was at its most powerful and least challenged. From the 1970s onwards there have been NHS reforms, mostly with the intention of exerting some form of control over the medical profession. I outline these reforms and the intentions behind them and consider them in relation to the proletarianization and deprofessionalisation theories. I ask how these challenges and developments have impacted on orthopaedic surgeons at the time when podiatric surgery was starting to emerge as a NHS service. I continue by discussing more recent changes within the NHS and their possible impact on medical autonomy. I then attempt to place the challenge to orthopaedic surgery from podiatric surgery in a context informed by the sociology of the professions.

In Chapter 3 I chart the development of podiatry. I explain the humble origins of the occupation and how members aspired to enhance their status by gaining state registration. The opposition of the medical profession to state registration is described along with the influence the profession continued to exert even after state registration was granted. The belief of podiatry leaders that the occupation would benefit from subservience to medicine is also described. I go on to detail the emergence of podiatric surgery beginning with the acquisition of the right to use local anaesthetics and following through to the present day where consultant podiatric surgeons are to be found in the NHS.

Chapter 4 follows a format introduced by Saks (1995) when he questioned why the medical profession was resistant to the establishment of acupuncture as a therapy. I suggest potential reasons why medicine should oppose podiatric surgery and discuss the merits of following certain hypotheses in the research process. In Chapter 7 I return to this format and reconsider these hypotheses in light of the data collected. I end Chapter 4 with a consideration of power theories chiefly involving the Neo-Weberian and Neo-Marxist perspectives and consider their potential application to the current study.

In Chapter 5 I explain the methodology of my research. I describe the use of questionnaires to collect data from both orthopaedic and podiatric surgeons. I go on to explain how personal interviews with orthopaedic surgeons were used to add richness and depth to the data generated by the questionnaires. I also provide an account of the difficulties I encountered in collecting my data and the barriers I had to overcome in order to access my target populations.

The results of the research are detailed in Chapter 6. These are provided with minimal commentary as I believe they are best presented in a form which allows the reader to gain an impression of the resultant themes. However, in order to provide more detail where appropriate, some frequency tables and crosstabulations are displayed.

Disclosure of results leads on to Chapter 7 where they are discussed in detail. The interprofessional conflict is considered from the viewpoint of both podiatric and orthopaedic surgeons. Key findings are analysed and I offer my interpretation of them together with implications which arise.

I follow this in Chapter 8 with a suggestion of how the findings affect the orthopaedic – podiatric relationship and what steps could be taken to bring about improvements. I conclude the chapter by considering possibilities for future research.

In Chapter 9 I form a conclusion from the results of my research and in the light of the discussion in Chapter 7. This final chapter summarises the emergence of podiatric surgery in the NHS and the resultant conflict between orthopaedic and podiatric surgeons. I then return to the research questions I posed in Chapter 1 and consider how they have been addressed by my findings. Finally, I summarise recommendations for improving orthopaedic-podiatric relations.

Chapter 2
Medical Dominance?

This chapter is the first of two which combine to describe the background against which conflict between orthopaedic and podiatric surgeons has occurred. The chapter is divided into three sections. The first explains how medicine evolved from a disparate group of occupations to become the dominant health-care profession. The second section discusses the challenges to the authority of the medical profession which arose from the 1970s onwards, and how these challenges created an opportunity for podiatric surgery to become established as a discipline in the NHS. In the third section I consider how existing sociological theories apply to the orthopaedic – podiatric conflict and attempt to place this conflict in an appropriate sociological context.

2.1 Establishing medical dominance

In the first half of the nineteenth century medicine was a profession of varying standards which lacked adhesion between its organisational bodies. The Royal College of Physicians, for example, had been incorporated in 1518 whilst, in contrast, surgeons were a craft-based occupation and in 1540 had joined the Barbers Guild of London though they separated from them in mid eighteenth century (Allsop, 2002). Standards of medical education in the nineteenth century varied and Dickens, in The Pickwick Papers, described medical students as a 'parcel of lazy, idle fellars, that are always smoking and drinking, and lounging ..... a parcel of young cutters and carvers of live people's bodies, that disgraces the lodgings.'

General standards improved with the passing of the 1858 Medical Registration Act which established the General Medical Council (GMC). In effect the GMC unified the

profession because it compiled a common register of all medically qualified practitioners which served to strengthen the power of doctors as a collective group against outsiders as did the Act itself, under which only those on the medical register could be employed by the state although unlicensed therapists continued to practise. Moran (1999 cited in Allsop, 2002) sees the Act as granting the medical profession a large degree of autonomy in determining what medical practice should be and how it should be performed as well as affording it state protection. From the mid 1800s onwards individual doctors were increasingly incorporated into professional bodies or institutions (Kelleher et al, 1994). By the end of the nineteenth century the demand for health-care had increased as had technological innovations (for instance, through developments in laboratory medicine). This created the need for forms of skilled assistance – auxiliaries – the utilisation of whom would make the treatment of larger numbers of patients possible. The expansion of such a subordinate division of labour was made possible by the 1911 National Health Insurance Act which made health insurance for lower-paid workers compulsory and for whom registered practitioners were to be the exclusive suppliers of treatment. Through this Act the state promoted health-care yet left the control of a new division of labour to the medical profession. Thus, the Act strengthened the economic position of the medically registered and the division of labour was constructed to support the status and income of those who controlled the market (Larkin, 1983; Saks, 1995).

During the first half of the twentieth century various groups of auxiliary workers sought to gain public recognition. However, it was difficult to break through what was, in effect, a doctor-state alliance. There were three routes they could follow: firstly, as with osteopathy, they could eschew medical support and rely on public appreciation for their recognition. To follow this path would be to limit the occupation to private work. Secondly, the occupation could petition for a Royal Charter. Such petitions were passed by the Privy

Council to the Ministry of Health and the major medical bodies for their views. The GMC, although without legal authority to pronounce on such matters, could recommend refusal from an established position. Thirdly, the occupation could attempt to gain state registration through an Act of Parliament. This, however, required mobilising support, hiring legal advisors and would face various forms of opposition; the laissez-faire culture present in Parliament at that time meant that there were objections to any form of monopoly. There were also concerns that the creation of a monopoly could raise the cost of treatments for the poor. In addition, medical members of both Houses could oppose bills thought to disadvantage their interests (Larkin, 1983).

Although there were some successes in gaining this sought-after recognition – Midwives, Dentists, Nurses – there were also failures, including bills seeking registration for chiropodists in 1928 and 1929 which are described in the next chapter. Even in the areas of successful recognition it is argued that, particularly with regard to midwifery and nursing, the medical profession continued in its dominant position (Larkin, 1983).

As a legacy of the First World War the ranks of auxiliary health-care workers had been swollen by partly-trained personnel on their demobilisation. As numbers in the various auxiliary occupations increased so did the desire of those occupations to gain formal recognition. Looking for an alternative to further legislation the Ministry of Health supported the British Medical Association (BMA) in 1936 in devising its own system of licensing – the Board of Registration of Medical Auxiliaries (BRMA). Affiliating occupations would work only under medical direction and would be dictated to by the BMA with regard to their training. Thus, prior to 1948, auxiliary medical (or paramedical) occupations would enjoy only a form of recognition which surrendered professional autonomy and which fell short of state registration.

From 1948 the formation of the National Health Service further affected the power and autonomy of the medical profession. Although some have suggested the establishment of the NHS reduced professional control for medicine, most argue that control actually increased (Saks 1995). An 'underlying concordat' was established between the state and the profession with respect to resource allocation. The state determined the level of resources to be allocated whilst the profession decided how to use them ensuring their clinical autonomy (Klein, 1983, cited in Elston, 1991). At a bureaucratic level doctors established a high level of representation on advisory bodies at the outset of the NHS and thereby exercised considerable influence over wide-scale medical policies (Saks 1995). Authority over paramedical groups was consolidated through legislative reforms (Larkin, 1983). For some, the first decades of the NHS represented a consolidation of the monopolisation of health-care by the medical profession and led to an inefficient service provision (Green, 1985 a, b, cited in Elston, 1991). This monopolisation ensured that external assessment and intervention was denied. Doctors controlled the review and rectification procedures associated with their work (Donaldson, 1994; Allsop and Mulcahy, 1996 cited in Allsop, 2002); senior doctors shaped the culture of their juniors (ensuring continuity of outlook) and were shielded from managerial control (Salter 1999; Harrison and Ahmed, 2000 cited in Allsop, 2002).

As the 1970s approached the profession demonstrated the three elements Willis (1994) considers necessary for medical dominance in the division of health-care labour:

autonomy – not subject to the direction and control of any other profession;

authority – power to direct the activities of all the other health occupations;

sovereignty – recognition as being the institutionalised experts on all matters relating to health in the wider society.

The profession continued to hold the power to direct the activities of other health-care occupations despite the passing of the 1960 Professions Supplementary to Medicine Act. As will be detailed in Chapter 3, this was the culmination of many years of protracted effort by the paramedical occupations, including chiropody, to gain state registration. Such a move had been opposed by the medical profession who had been wary of losing control over those occupations that had been considered 'auxiliaries'. I explain in the next chapter that this may have appeared, at face-value, to represent a reduction in control over paramedics by medicine yet Larkin (1983), for one, argues that this was not so much a case of losing influence but, instead, a method of consolidating it within a framework of statutory control. As such, it fits with Abbott's (1988) model of jurisdictional control. This concept is about a profession's control over its work and its influence and possible dominance over other professions. Jurisdictional claims can be made in the legal arena, in the area of public opinion, and in the workplace. Commonly, a claim is first made in the public quarter which may then lead to its adoption legally. For Abbott the medical profession had long enjoyed a full jurisdiction over sickness. The Medical Registration Act of 1858 had given the profession a legal status and public support had come from the middle classes. However, the jurisdictional concept is one which emphasises the dynamic processes by which professions interact with other professions or occupations. As a result a profession will, from time to time, face jurisdictional challenges from others. With the paramedical occupations united in their rejection of proposals under the Cope Report (see Chapter 3) which sought to further reduce their limited autonomy and increase control over them by the medical profession, a jurisdictional dispute arose. If Larkin (1983) is correct in his assessment of its effect, the 1960 PSM Act produced what Abbott terms a subordinate jurisdictional settlement (Abbott, 1988). In this concept a public and legal settlement results from an unsuccessful attempt to subdivide a full jurisdiction. In terms of the paramedical

occupations, the PSM Act brought statutory rather than medical control. However, medical representation on all occupational Boards established under the Act ensured significant influence in all areas of importance. Abbott explains that such a settlement may have great advantages for the profession holding jurisdiction but it can be inherently unstable. This instability would be illustrated within fifteen years with the introduction of podiatric surgery into the UK (see next chapter).

The high level of professional control which medicine demonstrated over health-care continued despite two unsuccessful attempts to curb medical power by NHS reorganisations in the 1970s and 80s (Annandale, 1998). The more radical reforms of the 1990s have arguably been more successful in reining-in medical power (Hunter, 1994; Light, 1995); however, the reforms created a climate that was conducive to podiatric surgery establishing a foothold as an accepted NHS service (Borthwick, 2005).

In the next section I consider the 1974 and 1982 NHS reorganisations but particularly the reforms of the 1990s and developments since that time, all of which can be viewed as challenges to the authority of medicine. These challenges are important because they create a pressurised climate for the medical profession. It is against this background that a further challenge arose to the orthopaedic monopoly of foot surgery from podiatric surgeons. The remainder of this chapter attempts to place these challenges in a sociological context utilising theories which have developed particularly to explain the situation which the medical profession faced but also using as a basis previously posited theories of power relations.

2.2 Challenging medicine

By the middle of the twentieth century medicine was 'at the height of public prestige, power, and authority' (Coburn and Willis, 2000:379). According to Freidson (1970) medicine had, by this time, become autonomous in all critical areas of health-care, that is, content of medical work, control of clients, and health-care policy. Medicine had acquired the most effective form of professional control where the practitioner defined both the needs of the client and the manner in which those needs were met. Johnson (1972) labelled this 'collegiate control'.

Freidson (1970) differentiated between 'autonomy' – the ability of a profession to control its own work activities – and 'dominance' – the ability of a profession to control the work of others in the health-care division of labour (what Willis [1994] termed 'authority'). Entering the second half of the twentieth century medicine had fulfilled Freidson's definitions of both autonomy and dominance. Some authorities disagree with Freidson's use of the term 'dominance', suggesting it infers 'zero conflict' whilst the reality is more likely to be regular manoeuvring for position between occupations attempting to improve their own relative positions (Larkin, 1983). Light (1995) also criticised Freidson's definition of autonomy as he argued that a profession cannot claim total autonomy whilst still dependent on the state socio-economically. This is relevant as economic considerations helped to provoke future NHS reforms as discussed below. Nevertheless, whatever the definitions of 'dominance' and 'autonomy', the hierarchical position of medicine within health-care is not disputed. By virtue of its own 'organised autonomy' it was able to dominate subordinate occupations like nursing and the paramedical professions, demonstrating almost hegemonic control (Coburn and Willis, 2000).

By the 1970s, however, medical power had become associated with rising costs – clinical autonomy meant that discussions about treatment for a particular patient were almost entirely in the hands of consultants who, it was argued, had no incentive to consider financial frugality. Faced with global economic crisis and general assent that the state was in 'fiscal crisis' the then Labour government attempted to restrict spending by introducing a management ethos. A system of 'consensus management' sought to manage the NHS by a group of equals, of fellow professionals, each representing the interests of a different occupation. It is argued that, whilst co-ordination of care may have improved under this system, it did little to curb medical power (Annandale, 1998).

In 1983 a management enquiry into the NHS was headed by Sir Roy Griffiths. This investigation concluded that 'consensus management' was not working and should be replaced with a system of 'general management'; here, one identifiable individual would be accountable at every organisational level (regional, district, unit). General management brought about some confrontation with the medical profession. By 1985 there had been:

- the imposition of a limited list of certain categories of drugs which could be prescribed in general practice;
- criticism of alleged misuse of their NHS contracts by consultants with regard to private practice;
- calls for ending consultants' NHS contracts for life (Elston, 1991).

Despite these disputes this system also largely failed to tame medical power (Harrison et al, 1992). By now, however, physicians perceived themselves to be in an acrimonious relationship with the state as evidenced by the BMA accusing the Secretary of State for Health of complicity in 'what appears to be a deliberate attempt ....to denigrate the work of doctors and undermine their standing in the public's eyes' (BMJ 1988, 297:1132 cited in Elston, 1991).

More radical changes were set in motion by the Conservative government's NHS and Community Care Act of 1990. The New Right viewed the health professions as self-interested monopolies which hindered the operation of what should be a market for health-care (Allsop and Saks, 2002). With a prevailing view that the NHS was costly and inefficient, handicapped by unnecessary bureaucracy, and existing more for the needs of the professional than of the patient (Annandale 1998), changes were introduced which were designed to reduce clinical freedom and hold doctors accountable for expenditure. This was to be achieved by changes which denoted a culture shift from a provider-driven service to a user-driven one (Hunter, 1994). A quasi-market was to be introduced to the NHS; providers of health-care (hospitals and community health-services) would compete with each other in order to secure contracts from purchasers (general practitioners and health authorities). Crucially, the patient was to be at the forefront of these changes, theoretically able to choose health-care options by way of the purchasers, and given new rights through the creation of a Patient's Charter (Annandale, 1998).

Whilst various commentators, in discussing the 1990s reforms, debate their effect on collective 'medical power' (Hunter, 1994; Coburn and Willis, 2000) it is more appropriate to consider certain sections of the medical profession separately. General Practitioners who, for so long, had been viewed as holding a subordinate position to hospital consultants now enjoyed increased power. As 'purchasers' of services they were able to place contracts with whichever hospital consultant they chose; indeed they were no longer restricted to referring patients within their own health service district but could literally send their patients anywhere in the country.

Hospital consultants, on the other hand, were faced with the possibility that the previously guaranteed stream of GP referrals could be reduced as a result of competition from other providers. For those orthopaedic surgeons who dealt with foot problems, the

evolving discipline of podiatric surgery represented such competition. From the security of mid twentieth century dominance of health matters, and having successfully resisted challenges to this dominance in both the 1970s and 1980s, the medical profession (specifically hospital consultants) was confronted with government reforms which had the capacity to challenge its hegemonic position. For orthopaedic surgeons there was even greater concern because, not only would these reforms create inter-disciplinary competition, but podiatric surgeons represented a threat to previously secure role boundaries. Before considering the expansion of podiatric surgery into the NHS it is pertinent to elaborate on the challenges to medical power during the period in question by examining the theories of proletarianization and deprofessionalisation. Light (1995) contends that sociological concepts of the professions such as these are not timeless, that is, they are products of their time. I would assert that any validity these theories may have for orthopaedic surgery would have been appropriately located in the time-span under consideration, that is, the 1990s and early 2000s.

Proletarianization

In this theory, which has formed from work conducted in the USA, the professionals are gradually being absorbed into the general mass of workers, that is, becoming part of the proletariat, under the effect of capital expansion (McKinlay and Stoeckle, 1988). This process is occurring as professionals accede control over their work content, work location, and so on, as they are forced to sell their credentialed knowledge on the labour market in much the same way as any other workers. As an example McKinlay and Stoeckle describe the American experience where the traditional situation, years ago, of many physicians working in independent practice has been replaced by large organisational structures

supported by capitalism. The proletarianization of physicians is defined as 'the process by which an occupational category is divested of control over certain prerogatives relating to the location, content, and essentiality of its task activities, thereby subordinating it to the broader requirements of production under advanced capitalism' (McKinlay and Stoeckle, 1988:200). With regard to Britain, Elston (1991) feels there is some applicability of this theory in the challenge to medical freedom from managerial accountability to the state as the buyer of medical services. However, it may be thought that the picture painted by McKinlay and Stoeckle (1988) is too extreme and I believe the arguments put forward by Derber (1982) and Derber et al (1990) are more realistic.

For Derber the proletarianized worker is someone who 'is powerless to shape the nature of his (sic) product or the process of his work' (Derber, 1982:7). As Annandale (1998) correctly observes, this is not a picture of a physician which most of us would recognise. Derber et al (1990) argue that the professionals have more power than the proletariat because of their credentialed knowledge and as a result the professionals and capitalism represent 'two intertwined systems of domination co-existing in relative harmony'. Annandale (1998) summarises Derber et al (1990) by saying that, whilst the proletarianization process may result in some reduction in the power of the physician, full proletarian status will never result because of the knowledge and therefore power which the physician holds.

Deprofessionalisation

This theory is advanced by Marie Haug who defines it as 'a loss to professional occupations of their unique qualities, particularly their monopoly over knowledge, public

belief in their services ethos and expectations of work autonomy and authority over clients' (Haug, 1973:197).

Essentially this situation has resulted from the combination of two factors: consumerism and increased medical knowledge. The latter has reached the extent that no one physician can encompass and keep track of all developments, resulting in medical specialism. With consumerism in health-care there is a challenge to medical knowledge from the populace through advanced communication processes and the media, and, as a result, some commentators viewed the 80s as marking the end of the 'passive' patient and the advent of 'active' consumerism (Stevens, 1986, cited in Elston, 1991). However, the theory of deprofessionalisation has not met with great support (Freidson, 1985, 1986; Elston, 1991; Annandale, 1998) and it is argued that, whilst consumerism was a feature of the 1990s reforms, it did not have a great effect on medical dominance. Annandale (1998) suggests that this may be because consumerism was not employed for the sake of the consumer but instead as a tool to impose the new reforms on the medical profession. She quotes Klein (1995:137):

> consumers were cast as the rank and file in the assault on provider power in the public services: the infantry who would follow-up the ministerial artillery barrage. The strong state, in other words, would draw its power from mobilising the people, by-passing (and so under-mining) the entrenched interests.

On the other hand, according to Hartley (2002), consumerism is considered to be a much more potent force in challenging professional dominance, particularly when allied to state policy evolutions and the action of health-care administrators; when these forces work together as a system they are capable of intensifying competition between physicians and other health-care professionals.

The concept of deprofessionalisation is given more credibility by Turner (1995) who argues that there are three ways in which it can take place which are not dependent on

consumers; all three have utility in the orthopaedics-podiatry situation. Firstly, a growth of bureaucracy results in a hierarchical structure of rules and authority which undermines professional autonomy. The NHS reforms of the 70s, 80s, and 90s, particularly with regard to the growth of managerialism, can be viewed as such a bureaucratic expansion. Secondly, the process of socialisation and development of knowledge may bring about a fragmentation of a profession into separate and distinctive groupings. Whilst orthopaedic and podiatric surgeons are not fragments of the same profession they can be viewed as somewhat complimentary therapists; certainly the aim of their interventions is the same. Although podiatric surgeons might boast of their own unique knowledge base the reality is that much of that base is derived from the socialisation and development of general surgical knowledge and this helped podiatric surgeons develop into a separate discipline. Finally, and with great relevance, deprofessionalisation can come about when 'para-professionals' encroach upon the domain of an established profession which is, of course, exemplified by the 'para-professional' podiatric surgeon encroaching upon the traditional occupational territory of the orthopaedic surgeon.

Following the 1990s reforms

Since Labour came to power in 1997 the focus of the NHS has changed to 'managed care' rather than 'marketisation'. This managerialist agenda can be referred to as New Public Management (NPM) which involves:

- greater 'disaggregation' of public sector organisations into separately managed units;
- enhanced competition coupled with the use of private sector managerial techniques;
- greater user choice of service provider;
- emphasis on 'discipline and parsimony' in resource use;

- greater 'hands-on' management;
- adoption of measurable standards of performance;
- use of 'pre-set output measures'

(Dent, 2003 citing Hood, 1995)

One of those elements sometimes discussed as a separate issue to managerialism is the concept of the patient as an active participant in their own health care, that is, the patient now has choices about their treatment (Dent, 2006). As a concept this seems to have gained more significance than consumerism did under the 1990s reforms. Both these concepts, managerialism and patient as participant, in theory, place differing but increased demands on the medical profession and therefore are likely to have some effect on the question of medical dominance.

In relation to managerialism, physicians now face forms of control both internal and external to their working environment. Internally they are accountable to hospital managers and senior medical managers within their Trust and externally they must satisfy the demands of new agencies such as the National Institute for Clinical Excellence (NICE). Whilst some see this simply as the rise of managerialism, and therefore a means of increasing production by reducing individual autonomy, others see it in a Foucauldian way in that performance/audit demands can encourage individuals to accept responsibility for meeting new requirements (Allsop, 2006).

Coburn (2006) elaborates on how increased assessment of medical practice has impacted on clinical autonomy. The trend for 'evidence-based medicine' has meant the evaluation of traditional methods of treatment and has resulted in the creation of clinical guidelines or protocols which may not always be followed but which are very difficult to ignore. The net results are that the esoteric knowledge base of medicine (on which much of medicine's autonomy is based – see Turner, 1995, in Chapter 7) is under threat, and

external sources can use these prescribed methods of treatment to manage or alter medical practice.

With regard to the concept of patient as active participant, it seems that most observers regard this as having limited effect on medical autonomy. Dent (2006) argues that while at first glance this could challenge the traditional hierarchical and patriarchal doctor-patient relationship, the result is likely to be an underpinning of medical dominance because the reality is that the typical patient will choose to ally him or herself with an individual physician. Tousijn (2006) concurs with this view. Whilst noting that the concept could, theoretically, result in such changes as low fidelity to a doctor, a low degree of patient compliance, and increased complaints, he reports that research has shown little evidence of this. He concludes that factors such as patient age, education, and seriousness of illness can discourage consumerism and foster dependence on a physician.

So, have these changes in practice, imposed since the reforms of the early 1990s, affected the issue of medical dominance? There are mixed views. Coburn (2006) notes a decline in the political power of the medical profession particularly in terms of setting or controlling political agendas. Whilst medicine 'can block reforms or encourage or channel others' it does not, on the whole, generate them. Politically the profession has become reactionary rather than determinative. Allsop (2006) supports this view, noting that medical authorities are no longer automatically consulted about policy changes and that some major health reforms have been introduced without consulting the medical profession. On the other hand, Allsop argues that, on a local basis, individual doctors may continue to play an increasingly important role in formulating strategy in priority areas of care.

Allsop sees a reduction in clinical autonomy resulting from systems for clinical governance and performance management, a view which is supported by Dent (2003) who also notes autonomy increasingly subordinated to external regulating agencies such as the

Commission for Health Care Excellence. Yet both commentators can provide a converse argument. Locally, some physicians have taken on management roles which can be seen to support government policy or could represent a means to pre-empt action by others or even to subvert managerial processes (Allsop, 2006). Dent (2003) agrees: medical protocols, designed by senior medics and not outsiders, may serve to protect medical autonomy rather than erode it because, once they are in place, there is no need for outsiders to interfere with them.

Both commentators agree that the rather unique status of doctors limits reduction of their autonomy. They retain control over medical knowledge and it is their expertise (which only they can really evaluate) on which hospitals are dependent (Dent 2003, 2006, Allsop 2006). Allsop also comments that:

> doctors remain in short supply and radical changes in the division of tasks between health care workers have not yet been achieved.
>
> (Allsop 2006:454)

The arguments presented here, however, would seem to be challenged by evidence of the relations between orthopaedic surgeons and podiatric surgeons. As I will explain in the next chapter, the orthopaedic speciality has failed to retain control over knowledge regarding surgery of the foot and, while a clear division of tasks in this respect has not occurred, there is certainly duplication of effort.

Returning to the general concept of medical dominance, both Allsop and Dent agree that dominance is not so much decreasing as going through a reconfiguration. As an example Allsop describes the government's plans for reforming the GMC as a probable transformation of power rather than a loss of control as the changes will involve medics playing key roles in the reassessment and reaccreditation of doctors (Allsop, 2006). This fits with Dent's (2006) assertion that professions and professionalism should be viewed as a

dynamic process and professional dominance has to be a negotiated settlement as it is continuously open to new challenges.

The final word in this appraisal of recent challenges to medical dominance comes from Willis (2006), not least because his observations have particular relevance to the current dispute between orthopaedic and podiatric surgeons. Having observed that evidence for and against a decline in medical dominance is hard to assess, he makes some observations on the question of dominance with regard to other health-care occupations. As he notes,

> boundaries between health occupations have become more fluid and less entrenched but that does not mean they don't exist.
>
> (Willis, 2006:427)

With regard to the situation in Australia he also reports that:

> Surgeons, the apex of the status hierarchy of the medical profession, have been able to resist these neo-liberal economic imperatives enshrined in competition policy more than most professional groups and have retained longer than most a form of professional organisation close to the traditional guild system.
>
> (Willis, 2006:426)

Australian surgeons, then, appear to have been particularly successful in facing challenges to their position of dominance. However, can the same be said of their British counterpart? In addition to the various forms of challenge arising over the last couple of decades or so the British orthopaedic surgeon has been faced with the additional challenge posed by a rival, evolving discipline – podiatric surgery. Have attempts to resist the expansion of podiatric surgery been simply a response to preserve existing role boundaries or could there be other explanations for non-acceptance? (See Chapter 4)

2.3 The Power Theories

In attempting to apply sociological theory to understanding the orthopaedic – podiatric conflict, I consider firstly two analyses of power relationships which have featured prominently in recent decades in sociological accounts of developments of the professions. These may be termed the Neo-Weberian and Neo-Marxist perspectives. Both perspectives developed in response to the Trait and Functionalist theories of the professions which essentially placed the professions in a favourable light, according to positive elements such as adherence to a code of ethics, altruism, and self-regulation. Both the Neo-Weberian and Neo-Marxist perspectives offer less complimentary views of the professions with the former focussing on control of the market for services and the latter concerned with modes of production and class theory (Coburn and Willis, 2000). After considering each of these in turn I discuss more recent additions to the debate which suggest that modern developments affecting health-care have rendered these perspectives too narrow.

Neo-Weberian

This perspective stresses those strategies designed to advance social status and dominate the market for services through the exclusion of competitors (Larkin, 1979). In this approach a profession is 'not so much a prestigious occupation as a method of controlling an occupation in the interest of preserving prestige and power' (Turner, 1985, cited in Borthwick, 1999a). Two features are central to this perspective: social closure and professional dominance. According to Parkin (1979), social closure is a process whereby certain groups act to restrict rewards and privileges to an exclusive collection of eligible parties. Parkin identified three forms of social closure – exclusion, usurpation, and dual closure – but it is the first which has most utility for this study. Effective exclusion could

be achieved through the use of two tools: legal monopolisation (Larkin, 1983; MacDonald, 1985) and credentialism (Parkin, 1979). The first is gained through an Act of Parliament but no such Act conferring a legal monopoly over surgical practice to any body of surgeons has ever been passed in the UK. Royal Chartering could offer the next most effective form of gaining a monopoly. As will be explained in the following chapter, it seems that the Royal College of Surgeons erroneously believed their Royal Charter gave them the right to control the practice of surgery in the U.K. However, in the face of podiatric surgery expansion, the RCS appealed to the Privy Council who corrected their misconception: the Charter gave the RCS the right to promote control, training and standards of their own members only (Borthwick, 2000). Podiatric surgeons, therefore, could not be legally excluded from the arena of foot surgery.

Without the benefits afforded by some form of monopoly, credentialism could not, on its own, form an effective exclusion strategy. For Parkin, (1979) credentials are an important device which limits the supply of entrants into a profession, thereby enhancing its market value. The ill-fated Commission on the Provision of Surgical Services (COPSS) inquiry of the early 1990s (see next chapter for a fuller description) involved an attempt by orthopaedic surgeons to control podiatric surgery through the use of credentialism. The stated aim of the inquiry was to establish ways in which foot surgery in the NHS could be improved through greater co-operation between those disciplines providing foot surgery. A system which would incorporate podiatric surgeons into the BOA, perhaps by way of licentiate status, was discussed (Gilbert, 1994). Under such a system the BOA would, presumably, control entry on the basis of credentials and, indeed, assume a significant amount of control over the practice of podiatric surgery generally. Harrison and Pollitt (1994) explain that incorporation is, in fact, one of two methods capable of controlling one profession by another, the other being direct attack. With the failure of the COPSS inquiry

to reach an agreement, and the use of credentialism inapplicable as a means of exclusion, direct attack, in various forms, on podiatric surgery by orthopaedic surgeons appears to have been the remaining option.

Neo-Marxist

The basic principles underlying this perspective are, of course, not new. Writing half-a-century ago C. Wright Mills described major national power as lying within three domains: the political, the economic, and the military. These domains are so powerful and interrelate to such an extent that they effectively make all important decisions for the masses; public opinion has such a small voice in comparison to this powerful elite that, in real terms, it has little effect (Mills, 1956).

Within this structure, Navarro (1986) places medicine as an intermediate form of power, subject to the superordinate elite. As Coburn and Willis (2000) assert, commerce has, at least, taken partial control over medicine because health-care represents a hugely beneficial opportunity for profit making. In keeping with this viewpoint, Turner (1995) explains that, for many Marxist writers, the professions serve as agents of capitalism; by contributing to the management and surveillance of the working class, and thereby exercising control on behalf of capitalism under the auspices of the state they contribute directly to the creation of a disciplined and subservient working class.

If these Marxist principles are considered in association with the related theories of proletarianization and deprofessionalisation, it puts the orthopaedic-podiatric situation in context. Perhaps orthopaedic surgeons felt threatened by the emergence of podiatric surgery and looked to the powerful elite (in this case the state) for protection. However, this provided no statutory protection as the surgeons' Royal Charter did not give them the

powers they expected. Furthermore, the state was willing to countenance an alternative source of surgical provision which was viewed as being more economically attractive.

Whether one is more inclined to side with the Neo-Weberian or the Neo-Marxist perspectives, Turner (1995) believes that an adequate sociological approach to the professions can combine both: while we need to consider the professions in relation to class structure and the economy, we can only evaluate any profession in detail if we examine its relation to the market. The utility of both perspectives to an analysis of the professions is confirmed by Larson (1980, cited in Turner, 1995) who describes professionalisation as a process by which the producers of services have attempted to constitute and manage a market for their expertise. This process has a profound effect on the distribution of wealth and status and thereby contributes to social inequality, especially between labour and capital.

Broadening the debate

Earlier in this chapter I reported some of the more recent views on the question of medical dominance. The Neo-Weberian and Neo-Marxist perspectives, certainly in the way I have applied them, tend to consider relations between two occupations, whether it be in terms of market competition or the influence of class structure. However, more recent commentators have broadened the issue to suggest that third parties have an increasing influence in such situations. Coburn (2006) believes that the closure theory is not incorrect but incomplete; he argues that elements such as the state (through increased bureaucracy as earlier discussed) and powerful drug companies now shape policy to such an extent that medicine should be examined as part of a changing political economy and not just considered within the field of competing professions. This view gains support from Dent (2003) who describes the impact of 'new jurisdictional claimants' such as 'appraisers, auditors, and

monitors of expert services'. Allsop (2006:453) talks of 'the pressure of global capitalism and international markets on the nation state' and concludes that this has brought 'a rupture to the customary relations between the state and the medical profession'. These commentators effectively update views expressed by Abbott who, in 1988, recognised the importance of 'other powerful actors in the world of professions.' Referring to

> a combination of invaders and external forces – business administrators.....
> the insurance companies, large corporations, and the government
> (Abbot, 1988:141)

he argued that a profession, albeit a dominant one, is unable to withstand such a coalition of forces and as a result that profession's exercise of power will become limited. Furthermore, the influence of these external agents will limit the power of individual professions in jurisdictional contests.

While Larson (1980) and Turner (1995) believe that a combination of the Neo-Weberian and Neo-Marxist perspectives offers a suitable approach to the professions, I would argue that Parkin's (1979) interpretation has additional utility for the orthopaedic-podiatric situation. Accepting that there is some overlap of concepts between the two perspectives above, Parkin explains that exclusion and exploitation can occur within one subordinate class, resulting in a stratum of socially excluded inferiors, that is, such conflict is not always between capital and labour. Leaving aside the argument about whether the professions are agents of the bourgeoisie, orthopaedic and podiatric surgeons lie, I believe, in a similar, if unbalanced, level of stratification. It is true that the former have always enjoyed a superordinate position over the latter in terms of income and prestige. However, in the late twentieth/early twenty first centuries the differences between their social standing are far less than those between the orthopaedic surgeon and the chiropodist in, say, the 1950s. It is not therefore appropriate to regard conflict between the two as a class struggle but more accurate to describe it as a power struggle between two unequal groups

within the same stratification. In other words, orthopaedic and podiatric surgeons should not be viewed as belonging to different classes. They are, in effect, status groups within one class who are both vying for superiority. The conflict, then, is not a class issue but one which revolves around an attempt by one group at occupational closure. Closure is required here as a means of maintaining the group's pre-eminent market position in the face of competition from a rival.

Larson (1980) talked of professionalisation as a means of constituting and managing a market with wealth and status the rewards for success but, for the medical profession, a threat to this process is posed by the concept of 'multi-professionalism'. Tousijn (2006) reports that this concept – more simply labelled 'team-work' – is growing fast; it stems from the rise of many 'new' health-care professions who, bolstered by strong and expanding knowledge bases, are all seen as having important contributions to make in caring for patients. For Tousijn this represents a 'real break with the old professional logic' and is bringing about a blurring of traditional inter-professional boundaries (Tousijn, 2006:476).

Such a trend poses questions about the maintenance of the traditional status of orthopaedic surgery and offers encouragement to the developmental aspirations of podiatric surgery. With regard to podiatric surgery orthopaedic surgeons appear to be attempting to 'buck the trend' and are using exclusionary tactics to resist the advance of 'multi-professionalism'. They are striving to maintain their pre-eminent market position despite the prevailing political climate which has served to increase the number of agents having the possible capacity to reduce their autonomy. To achieve their goal, orthopaedic surgeons may rely on their continuing importance in health-care, indeed the dependency upon them by hospitals, and employ exclusionary tactics against competitors in order to effect occupational closure.

Most prominent among the 'new jurisdictional agents' is the state which podiatric surgeons may utilise in their aim of usurpation, particularly by turning the need for cost containment and the implications resulting from 'evidence-based medicine' to their advantage. By forming an 'alliance' with the state podiatric surgeons would conform to the model of 'countervailing powers' proposed by Light (1995) and Hartley (2002) which was described in Chapter 1. In this 'alliance' the role of the state would be underlined by the fact that 'multi-professionalism' is a feature of health policy reforms of the present government (Borthwick and Dowd, 2004). Some podiatric surgeons may have reservation about collaboration with orthopaedic surgeons but any government policy which serves to erode inter-professional boundaries is likely to be welcomed as a way of facilitating development of the profession of podiatric surgery.

To summarise, with regard to the orthopaedic-podiatric conflict, two rival disciplines are competing for occupational territory. The Neo-Weberian perspective provides some background to this dispute as control of a market is at stake. However, in itself this perspective is too restrictive as other agents, for example the state, have significant roles in shaping policy and practice. As such, an attempt by one discipline at occupational closure is faced with a number of initiatives from various interested sources which make such closure problematic. Nevertheless, for some in this discipline there remains an appeal in what Tousijn (2006) terms 'the old professionalism'. To try to ensure this endures they will attempt to resist initiatives which threaten change, particularly those which could establish 'multi-professionalism'. For the competing discipline state policy trends offer a means of countering attempts at occupational closure and a way to capitalise on opportunities for professional expansion. These considerations provide the theoretical background to my analysis of the relationship between orthopaedic and podiatric surgeons.

In this chapter I have described how the medical profession has come to dominate health-care, considered how developments in the later part of the twentieth century have threatened medicine's position of authority, and developed a sociological framework for understanding the challenges posed by the development of podiatric surgery to orthopaedic surgery. In the next chapter I provide an account of the rise of podiatric surgery, and of podiatry as a discipline, and, in so doing, I describe disputes which have arisen as the medical profession has sought to keep podiatry in a subordinate position. This shapes the background setting against which the conflict between orthopaedic and podiatric surgeons can be more readily understood.

Chapter 3
The Development of Podiatry

The hegemonic position of the medical profession in the provision of healthcare has been highlighted in the previous chapters. It follows that, historically, the paramedical occupations have accepted a subordinate position to medicine and, until the latter half of the twentieth century, podiatry conformed to this pattern. The period from the 1970s to the present day, however, is characterised by challenges to medical domination by podiatry, in particular regarding role boundaries and the division of labour. In this chapter I chart the development of podiatry from the beginning of the twentieth century to the present day. I describe the key areas of interaction between podiatry and medicine involving podiatry's attempts to professionalise and medicine's attempts to maintain its dominant position. I place these significant events in a context informed by the sociology of the professions.

There is relatively scarce sociological literature regarding podiatry. The early part of the following account is informed by Dagnall (1956, 1963, 1970, 1979, 1985, 1987, 1992, 1995 a,b,c) a podiatry historian, who has described the origins of chiropody (later to be called podiatry) and a subsequent organisational development throughout much of the twentieth century. Larkin (1983) focused on podiatry development in the earlier part of the century culminating in the conferment of state registration in 1960, and the relationship between the state and the allied health professions (Larkin 1995, 2002). More recently Borthwick (1999a, b, 2000, 2001 a,b,c, 2002, 2003, 2004, 2005 a,b) has considered the question of medical dominance over podiatry with particular reference to professionalisation strategies employed by podiatry during the last century. In 2004, when I was more than half-way through the current study, Borthwick and Dowd published a paper 'Medical dominance or collaborative partnership? Orthopaedic views on podiatric surgery.'

This paper resulted from ten semi-structured interviews with orthopaedic surgeons and attempted to cover some of the same issues as the current study. The authors acknowledge that their study was subject to limitations because of the small number of respondents involved. Nevertheless, I found their results valuable and consider them in Chapter 7, agreeing with some and questioning others in the light of my own findings.

3.1 Early attempts at organisation

A general description of chiropody at the beginning of the twentieth century is provided by Dagnall:

> Chiropody was a well-established craft with developed techniques and its own literature, usefully serving the public in a sphere neglected by the medical profession. There were many able professionals practising in a professional and ethical manner, but as individuals with no co-ordinating professional body.
>
> (Dagnall, 1970:315)

In 1912 a Society of Chiropodists was formed which was incorporated three years later. At this time chiropodists could be divided into two broad groups: firstly part-time empirics – 'corn cutters' – and secondly a group of full-time practitioners whose skills had been passed down from parents to children and who, generally, treated wealthy patrons. Despite the association of this latter group with the higher classes, chiropody was an occupation with a low esteem and poor image and was largely ignored by the medical profession. Larkin (1983) explains that doctors have frequently been eager to promote a division between themselves and others so that tasks which are undervalued or 'unpleasant' can be passed on in the division of labour; apparently, at this stage, the treatment of foot-ailments represented an example of an 'unpleasant' task. On the other hand, innovating groups in health-care have often begun from humble origins, dealing with 'unwanted tasks' and then engaging in tactics designed to promote upward mobility (Rosen, 1972 cited in

Larkin, 1983). Radiology and pathology (now highly-regarded medical specialities) both developed from such undervalued origins (Larkin, 1983).

Once established, the Incorporated Society of Chiropodists' first attempt at upward mobility involved the enlistment of a prominent medic, Dr Arnold Oxford, as an advisor and honorary treasurer. He, in turn, enlisted the services of a surgeon, Mr Norman Lake, firstly as guest lecturer and later as medical director of the newly established training school of the Incorporated Society. Lake reported disquiet amongst his peers concerning his association with chiropody; Lake and Oxford were anxious to avoid conflict with their medical colleagues and imposed restrictions on advertising on members of the Incorporated Society. The use of terms such as 'surgeon', 'professional', or even 'certified chiropodist' was banned (Larkin, 1983).

This strong reluctance of the medical profession to associate with chiropody may have had much to do with the desire to channel 'unwanted tasks' elsewhere which was previously noted. However, it is also possible that there was a general antipathy towards 'empirics' at this stage as Saks (1995) has noted when considering medicine's attitude towards acupuncturists. At this time medical orthodoxy was stressing the need for a greater degree of scientific understanding in medicine – this helped to increase power and status of doctors by reducing the ability of the public to evaluate their performance.

For the next decade, up until the late 1920s, chiropody continued with its quest for upward mobility, with medicine apparently largely unperturbed as it recognised the lowly status of chiropody. By this time a policy of subservience to the medical profession by chiropody was discernible. *The Medical Press* (cited in *The Chiropodist* 1924:23) emphasised that the chiropodist 'neither pretends nor desires to travel beyond his sphere of operation'. In 1925 *The Lancet* reviewed 'Practical Chiropody', a book by Runting, a founder member of the Incorporated Society. The review explained that Runting had

warned chiropodists not to extend their sphere of practice and to always involve a doctor where foot problems involved systemic rather than solely local disorders. However, the reviewer objected to Runting's definition of chiropody which included the treatment of joints in the foot – these were strictly the province of the doctor or the orthopaedic surgeon.

3.2 The quest for state-registration

With both medicine and chiropody recognising the subordinate position of the latter, chiropodists pressed ahead with an attempt at gaining state registration, no doubt encouraged by the success of the dentists in gaining such registration in 1921. In 1928 a bill for registration was introduced into the House of Lords but the British Medical Association communicated their objections to the Ministry of Health which was staffed at senior levels by doctors. Consequently the medical peers of the House of Lords were approached and persuaded to ensure that the bill failed (Larkin, 1983). The reasons behind the objections of the BMA were: firstly, the definition of chiropody within the bill offended the medical authorities in that it appeared to claim all responsibility for foot ailments except those requiring major surgery. Secondly, the bill proposed a Chiropodists Board which would regulate the profession but on which medical representatives would be in a minority (Larkin, 1983).

The Midwives Act (1902), Nurses Act (1919) and Dentists Act (1921) had introduced the concept of self-regulation amongst some health-care occupations. Further legal recognition of paramedical occupations could mean that 'medicine was in danger of dilution, fragmentation and decline' (Larkin, 2002); it was therefore necessary to block further attempts at gaining state registration in order to ensure 'the continuity of supervised subordination' (Larkin, 2002).

A second bill in 1929 also failed despite a dilution of the definition of chiropody contained in the first bill and the medical profession's unease with chiropody was evident from an article in *The Medical Press* (April 3, 1929); the article denigrated the leaders of the Incorporated Society and rebutted chiropodists' claim to rights of diagnosis as these should only be granted to the medically qualified. Clearly, state-registration would confer official approval on chiropodists and support them in their claim of a right to diagnose.

Willis (1994), who sees the evolution of the division of labour in health-care very much as a power struggle, identifies four methods by which the dominant profession may seek to prevail over others. Firstly, there is **exclusion** where the emergent occupation is denied official legitimacy through refusal of registration Acts, denial of access to hospital use, and so on. The failure of the bills introduced in 1928 and 1929 are examples of the former and the latter would be highlighted some sixty years later in the current conflict between orthopaedic and podiatric surgeons. Secondly, the dominant profession may seek to **subordinate** others. An example of this is that traditionally nurses have had their work largely directed by doctors. Chiropodists have been unique amongst the paramedical occupations in that they have always claimed the right to diagnose, a cause of annoyance to the medical profession as noted above. Complete subordination of chiropody to medicine was difficult whilst this right was still claimed. However the subservient attitude generally apparent amongst the chiropody leaders at this time effectively created a subordinate state. Medicine would seek to reinforce this within a few years by an official limitation of the chiropodist's scope of practice (see below) - **limitation** being the third of Willis' modes of domination. The fourth, and final, of these methods is **incorporation.** Absorption of an occupation into the medical profession or, at least, under its 'umbrella' of control maintains medicine's dominant position. This process was first mooted in the early 1930s when the BMA was establishing a new body, the Board of Registration of Medical Auxiliaries

(BRMA). In order to be accepted into this body, podiatrists would have to accept the following definition of their work:

> The treatment of abnormal nails and all superficial excrescences occurring on the feet such as corns, warts, callosities and bunions. Each (chiropodist) undertakes, (1) to confine his or her practice to the above mentioned conditions, (2) not even within the above field to operate for (a) any congenital or acquired deformity, (b) any condition requiring a general anaesthetic or a local anaesthetic given by injection, (c) any condition involving any structure below the level of the true skin, (3) not to deal with any patient who is at the time under the care of a medical practitioner without his knowledge and consent.
>
> (*BMJ*, 1934:S149 cited in Larkin, 1983)

Urging his colleagues to support the registration of chiropodists the chairman of the BMA, Sir Henry Brackenbury explained:

> they had to recognise the common sense facts –viz that these conditions existed, that they now had the opportunity of keeping the chiropodist in his own place, and they ought to seize that opportunity of binding the main body of chiropodists to the acceptance of the prescribed limitations.
>
> (*BMJ*, 1934:S67 cited in Larkin, 1983)

Although the council of the BMA initially rejected this proposal for chiropody registration, they changed their minds over the course of the next few years. Chiropody started to become more popular with the public and when it became obvious to the medical authorities that they could not prevent its development they decided they would be better off controlling it (Larkin, 1983). Registration was therefore again proposed and granted in 1938, under the limitations imposed by the definition given earlier. It should be noted that whilst the subservient attitude of chiropodists earlier described continued to be apparent there was some dissent on the limitations to practice which this registration signified. It was claimed that chiropodists had allowed the medical authorities to 'bind them in chains' for a form of licensing which lacked legal status (*BCJ*, 1937:72) in that registration with the BMA fell short of formal state-registration. Despite these objections, chiropody had undergone a form of incorporation which would persist until official state-registration in 1960. The possibility of incorporation as a method of control would re-emerge sixty years

later when orthopaedic surgeons sought to control podiatric surgeons (see the COPSS report later in this chapter).

By 1948 the BMA licensed some paramedical occupations but not others. Physiotherapists, for example, had withdrawn from membership of the BRMA in 1944 when it became evident that support from the BMA towards gaining state-registration would not be forthcoming and that the BMA only sought to control paramedical occupations (Larkin 1983). The BMA wanted the Ministry of Health to strengthen the position of the Board either by forcing non-compliant occupations into membership or by giving the Board statutory state powers. At this time the advent of the new National Health Service was looming and instead of agreeing to the demands of the BMA, the Ministry set up a Committee of Enquiry to report on the supply, demand, training and qualifications of medical auxiliaries to be employed in the NHS. The chairman of this committee was Dr Zachary Cope, previously a member of the BRMA. Both the structure of the committee and its resultant recommendations were further evidence of the desire of the medical profession to maintain and even maximise control over the paramedical occupations. Under the direction of Cope eight sub-committee were formed, each dealing with a separate paramedical occupation. On each sub-committee members of that paramedical occupation were in a minority, outnumbered by medical personnel and civil servants. Whilst the sub-committees met under the co-ordination of Cope there was never a plenary session which had the effect of keeping the paramedical occupations apart in the important decision making. The resultant proposals from the Cope Committees were, firstly, that the BRMA system should be rejected because of its limited jurisdiction and, secondly, that a statutory body should be established to oversee the training of medical auxiliaries, to ensure that medical advances were incorporated into that training, and to rule on demarcation disputes among medical auxiliaries (Larkin, 1983).

These measures were to be achieved through the creation of a supervisory council which was to be advised by eight subordinate boards. Medical auxiliaries were to form a majority on these subordinate boards but this majority was not to be greater than three fifths of the membership and, even then, those medical auxiliary members were to be nominated by the council and not elected by their peers. Representation of medical auxiliaries on the Council itself was to be even less generous: eight doctors were to be joined by a further seven medical or lay people with only six medical auxiliaries who were to be nominated by the eight subordinate boards. Thus, not every paramedical occupation was to be directly represented on the Council (Larkin, 1983).

Incorporation under the BRMA had given the medical profession a certain amount of formal control over chiropodists but under these new proposals the limited autonomy of the chiropodist would be further reduced. The Cope Report stated:

> From the nature of their work there is a risk that chiropodists may be led into undertaking treatment for a complaint which is more serious than at first appears. We believe that this difficulty is brought about because of the long established practice whereby the public go directly to the chiropodists rather than approaching them through medical practitioners.
>
> (HMSO, 1951 Cmnd.8188:36, cited in Larkin 1983)

The Cope Report brought a backlash of resistance from the paramedical occupations which had previously been characterised by a marked subservience to the medical profession. Nine out of seventeen medical auxiliaries on the Cope Committees signed minority dissenting reports. Objections were registered against the Report which was seen as undermining professional responsibility thereby adversely affecting the quality of service offered, and denying medical auxiliaries corporate representation on a body for whom it was designed. In keeping with subservient tradition, the two chiropody members on the Cope Committees did *not* sign dissenting reports. However, Larkin (1983) does report concern in the Society of Chiropodists regarding further erosion of professional autonomy.

There was certainly sufficient solidarity amongst the paramedical occupations to persuade the Ministry of Health to abandon the recommendations of the Cope Report. The rejection of the Cope Report was not well received in medical circles. *The Lancet*, a traditionally liberal publication, stated that

> .....most of us are convinced that the fragmentation of medicine has already gone too far, and that the time has come, in the interests of patients, to re-assert the true doctor's predominance over technicians of whatever kind.
>
> (*The Lancet*, 1951:895)

The *BMJ* argued that:

> There is a very great danger in the attempts to foster independence of medical auxiliaries from the medical profession – in fostering further specialisation outside the control of the doctor, on whom ultimate responsibility for the patient must ultimately lie.
>
> (*BMJ*, 1953:1267)

Despite these assertions, following the rejection of the Cope Report, the Ministry of Health set up a further working party composed of members of the paramedical occupations but this time excluding members of the BMA or the medical corporations. The working party's recommendations eventually led to the formation of a single body, the Council for Professions Supplementary to Medicine (CPSM), which would regulate the paramedical occupations. After speech therapists withdrew their participation, the composition of the Council eventually involved seven paramedics, seven doctors and seven lay people. Medical membership of the Council ensured there would be medical monitoring but not control over paramedical matters. The Council would be advised by seven Boards, one for each paramedical occupation. The Boards were to determine training curricula and examination content, appropriate qualifications, adjudicate on ethical issues, and maintain a register. The Council, in turn, would advise the Privy Council.

The removal of outright medical control over paramedical occupations caused consternation in some quarters. Radiologists complained that it was:

> 'analogous to staffing the Coal Board with a majority of coalminers. ... It is essential that all medical auxiliaries must be prepared to carry out instructions and that they cannot be considered as autonomous professions intervening between doctors and patients. ... The duties of auxiliaries are to relieve doctors of minor routine tasks, but since a little learning is a dangerous thing, many of them think they can extend their activities and take over some of the responsibilities of doctors. It cannot be over-emphasised that auxiliaries lack the primary and secondary education necessary to understand and deal with sick people. Unlike doctors and nurses, their calling is not a vocation. In background and training they rank well below nurses. Nobody would suggest that a committee concerned with the nursing of patients should have a majority of nurses or a nurse as chairman – yet it is proposed that auxiliaries, with half the training required for nurses, should have major representation in affairs which are equally vital to the welfare of the patient. If such a status is granted to auxiliaries it could easily result in legalised quackery and do incalculable harm, not only to patients, but to the whole structure of the NHS.
>
> (Faculty of Radiologists, 1956)

In this quotation certain sentiments are expressed which I would encounter, nearly fifty years later, during this current research, particularly with my personal interviews with orthopaedic surgeons. Although I will later return to these comments when discussing the results of my research the existence of the following should be noted:

- a belief in the outright superiority of the doctor over the paramedic;
- paramedics are seen to lack the education and training necessary to treat the sick independently;
- the medically qualified should direct the activities of those not medically qualified;
- only the medically qualified should provide the more advanced forms of treatment.

The Professions Supplementary to Medicine Act 1960 made statutory the regulation of paramedical occupations and gave chiropody state-registration. Following the passing of the Act there was little comment in the medical press. There was, however, one observation in the *BMJ* which was prophetic in the light of the future emergence of podiatric surgery; the main risk as a result of the Act was of 'specialisation outside the control of the doctor' (*BMJ*, 1960:1375)

At first examination, the move from registration of chiropody under the BRMA to regulation under the CPSM represented a reduction in medical control. This point is analysed by Larkin who accepts that, following the 1960 Act, medicine's direct control over the paramedical occupations ended but argues that significant influence continued (Larkin, 2002). Prior to the Act the state closed off all avenues of advance to paramedics except those approved by the medical profession; for Larkin (1983) state registration did not dissolve this system but preserved it by buttressing it within a framework of statutory legislation. Furthermore, state registration did not bring to the paramedics any change in the role boundaries from those imposed by medicine in previous decades. When he expressed this view Larkin was probably not aware of the emerging new speciality of podiatric surgery which clearly has subsequently altered role boundaries. Larkin is, however, correct in his basic premise that state registration did not, *per se*, alter role boundaries. Certainly, medical representation on the Chiropodists Board of the CPSM contrived to contain expansion of the chiropodist's scope of practice until the exploitation of a loophole in the legislation gave chiropodists access to the use of local anaesthetics; with their availability the way was open to develop surgical techniques and further expand the scope of practice. I explain this further after the next section but before leaving the issue of state-sanctioned medical control over paramedical occupations the most recent and radical change in this area should be noted.

3.2.1 A new format for registration

Following the PSM Act 1960 there were no significant changes in the nature of legislation with regard to paramedical occupations for the remainder of the twentieth century. However, under the Health Professions order 2001 the Council for Professions

Supplementary to Medicine was replaced by the Health Professions Council (HPC). This new body was formed to represent thirteen paramedical professions. The Council is formed by twenty six members – one representative from each of the professions and twelve lay members plus a president. The Council is supported by four statutory committees which deal with conduct and competence, the health of HPC registered professionals, the investigation of complaints, and education and training. There is additional support from some non-statutory committees, the number of which may be increased at any time. Borthwick (1997) viewed this development as a reduction in the self-regulatory powers of the paramedical professions and suspected that a strong medical representation on the Council would mean greater medical control and authority over the scope of paramedical practice. However, by 2006 his fears appeared to be unfounded; the lay members of the Council, at this time, were not members of the medical profession although a single medical representative sat on each of the conduct and competence, health, and investigation committees as stipulated in the 2001 order.

3.3 A change of name

The remainder of this account charts the development of podiatry from the 1960s and from this point I use the terms 'podiatrist' and 'podiatry' instead of 'chiropodist' and 'chiropody'. In Britain the use of the former terms really stem from the formation of The Podiatry Association in the 1970s. This body sought to expand scope of practice by the development of surgical techniques and full members of the Association called themselves 'podiatrists' instead of 'chiropodists'. By embracing surgical techniques podiatrists came to be regarded as representing clinical advancement and excellence. With this in mind, the 'rank and file' members of the Society of Chiropodists saw the adoption of the term 'podiatrist' as a means of distancing themselves from the poor public image associated with

the term 'chiropodist' (Borthwick, 1997). As a result the Society of Chiropodists changed its name to the Society of Chiropodists and Podiatrists in 1993 and between 1989-92 the educational qualification of the state registered training schools changed from diploma to degree status and BSc (Hons) in Podiatry became the norm for successful qualification. Whilst 'podiatrist' and 'podiatry' did not therefore come into general use until near the end of the twentieth century, I feel it is appropriate to use these terms earlier in my account as the development of the advanced techniques which led to their adoption began in the 1960s.

3.4 Starting to challenge medicine – the fight for local anaesthetics

The first successful challenge to medical determination of role boundaries and skill range in podiatry since the acceptance of BRMA auxiliary status in 1938 came from legal recognition of the right to use local anaesthetics (Borthwick, 1997). The 1938 registration had forbidden any form of operation under the 'true skin' which ruled out the use of local anaesthetics. There was however, no legal impediment to its use. A small number of podiatrists had learned local anaesthetic techniques during military service in the Second World War and National Service in the 1950s. When they started to employ these techniques in private practice during the 1960s they were able to do so under the rather vague wording of the 1960 PSM Act which stated that the practitioner could undertake 'that which he is trained to do'. The Society of Chiropodists, as ever subservient to medicine, was concerned that using local anaesthetics could open up the possibilities of podiatric surgery which would be certain to bring the profession into conflict with the medical authorities (*The Chiropodist*,1965). The reluctance of the Society to support the use of local anaesthetics was compounded by the Medicines Act in 1968 which reclassified drugs, placing local anaesthetics in the Prescription Only Medicines category; only doctors, dentists and vets were permitted access to these.

In 1967 the Chiropodists Board of the CPSM set up a working party to examine the possibility of podiatrists using local anaesthetics. Although podiatrists were in a numerical majority on the Board this was not so in the case of the working party where there was a majority of medical members. The report of the working party (endorsed by the Board) concluded that podiatrists should not have access to local anaesthetics chiefly because their training was inadequate and because such use would constitute a danger to the public.

Faced with the conclusion of this report in 1968 some like-minded podiatrists banded together to form the Croydon Postgraduate Group whose aim was to develop local anaesthetic techniques and thereby expand the podiatrist's scope of practice. They were able to follow this aim, despite the Chiropodists Board report, because of the PSM Act 1960 definition of podiatry described earlier. On the strength of this definition, the podiatrist could use local anaesthetics if he or she was 'trained' to do so.

Early courses arranged by the Croydon Group were run without insurance cover and, whilst the Group did manage to secure help from individual members of the medical profession, their input was understandably limited when no insurance cover was in place. Many podiatrists were attracted to the Group's courses as they could see the potential for expanding their scope of practice. Faced with the success of the Group's courses and the high standards they insisted upon, the Society of Chiropodists not only arranged insurance cover for the Group but also set up its own syllabus and examination system in local anaesthesia. There followed a formal application to the Chiropodists Board for the right to use local anaesthetics. Medical representatives on the Board ensured the application failed (Borthwick 1997). The Board claimed that the syllabus was inadequate so the Society duly adjusted it and presented it as a postgraduate course of thirty hours duration. This time outline approval was given provided that training in local anaesthesia would be examined by a consultant anaesthetist and not a podiatrist.

Borthwick (1997) explains that the success of this application was not, as the Society suggested, the result of technical improvements in local anaesthetic delivery but, instead, more a case of serendipity. On the day of the crucial Board meeting some key medical opponents were absent.

> The Chiropodists Board then determined in 20 minutes on a wet Friday afternoon, with a very poor medical attendance at the Board meeting, and only sympathetic ones at the Board meeting ..... sometimes things can get slipped through because certain people are not attending, they're not following the drift of the thing. Certainly there were medical members, I can assure you, if they had been present at that meeting ..... no way, if they had been present, would that ever have got through.
>
> (Key Informant, Borthwick, 1997)

The result of the Chiropodists Board acceptance of podiatric administration of local anaesthetics was that the 1938 limitation of scope of practice relating to the 'true skin and its excrescences' had well and truly been lifted. More crucially, allied to the definition of podiatry under the 1960 Act, the implication was that scope of practice could be expanded as long as training was provided.

3.5 Pushing back the role boundaries – the beginnings of podiatric surgery

Following the official approval of local anaesthetic techniques by podiatrists, the Croydon Postgraduate Group expanded its activities into surgical areas. Initially nail ablations were performed but soon digital surgery began to be undertaken. From the Croydon Group the Podiatry Association emerged in the 1970s. This body soon gained national eminence and came to challenge the Society of Chiropodists as the pre-eminent podiatric organisation. It also 'challenged the dominance of medicine in determining the limits of podiatric surgery,

adopting a more confrontational approach to the medical profession than had previously been the norm' (Borthwick, 1997).

Whereas the Society of Chiropodists had traditionally sought medical endorsement of any advance in practice, the Podiatry Association (& particularly the Croydon Group) followed a different approach. The Croydon Group had felt that the way forward was to establish surgical practice without drawing attention to the fact, and certainly without seeking medical approval. They argued that, if surgical practice could be established for 5 years, then, under common law, there would be a right to practise podiatric surgery without medical interference. Initially members drew upon the experience of colleagues in military service for minor surgical and radiographic techniques. Later, members visited the USA, learned American podiatric surgery techniques, and also invited American podiatrists to visit Britain and teach these techniques (Borthwick, 2005).

As the activities and membership of the Podiatry Association increased, the Chiropodists Board received enquiries regarding their activities. These came from medical bodies such as the Faculty of Anaesthetists, and the Royal College of Radiologists who were concerned about encroachment upon the field of radiography. Of more significance, however, was the interest of the Royal College of Surgery. In 1980 the Royal College wrote to the CPSM:

> The working party of the College .... has for so long been considering what advice it should offer to assist the Chiropodists Board to protect the practice of chiropody from the infiltration of podiatrists has at last reached a conclusion ... That in the interest of patients' safety, chiropodists should be allowed to operate only upon the skin of the foot and those structures (such as callosities and toenails) which derive from it. This resolution is being forwarded to the Conference of Medical Royal Colleges and their Faculties in the UK, if they agree, (will) be able to bring it to the attention of Health Authorities
>
> (Johnson-Gilbert, 1980, cited in Borthwick, 1997)

Interference from the RCS was not well received by the Chiropodists Board who pointed out that the RCS had no authority to define podiatric practice. The Board then

demonstrably promoted podiatric surgery by convening an advisory committee on the development of surgical practice in podiatry.

The BOA responded by directing its members to disassociate themselves from podiatry.

> An increasing number of these practitioners, who have no basic surgical training are appearing in Great Britain and are known to carry out orthopaedic operations on feet and, it would seem, higher up in the lower limb ... The appearance of a 'service' of this type suggests to some extent, a failure on the part of orthopaedic surgeons to satisfy demand ... The Executive also wished to stress the undesirability of any direct association between the BOA and podiatrists, in particular with regard to training in operative techniques."
>
> (BOA, 1981)

The BOA circulated copies of its directive to a wide variety of medical bodies.

Correspondence to the Society of Chiropodists advanced the view that surgery should not be undertaken by "non-medically trained" personnel and that podiatry should be limited to the definition agreed upon in 1938. The Joint Consultants Committee of the BMA leant support to the BOA by endorsing the view that surgery should only be performed by medically qualified personnel (*BMJ*, 1982).

Despite the BOA remaining adamant in their stance against podiatric surgery, in 1986 the Chiropodists Board formally asserted the legitimacy of the use of surgical techniques by state registered podiatrists by modifying their Statement of Conduct; this amendment also established the phrase 'ambulatory foot surgery' which denoted foot surgery to be performed under local anaesthesia and on a day-case basis.

3.6 Podiatric surgery in the NHS

Until the 1990s the vast majority of podiatric surgery was performed in private practice with little occurring in the NHS. As outlined in the previous chapters, the NHS reforms of the early 90s changed this, as medical authority in administration declined in direct response to a change of culture in the NHS and a shift towards general management heralded by the NHS and Community Care Act (1990). These management changes emphasised the need for health services to operate within a competitive market place and to demonstrate value for money; clinical audit became an important tool in evaluating the effectiveness of any form of service provision. Podiatric surgery, which could be provided on a day-case basis and without the need for general anaesthesia, was found to be both cost effective and clinically effective. It therefore found favour with NHS managers, in particular those whose duty it was to purchase services. With NHS managers determining provision of services, and medical authority greatly restricted, podiatric surgery gained entry to the NHS on a scale never seen before, even though numbers of podiatric surgeons employed within the NHS remained very small in comparison with those of orthopaedic surgeons.

The involvement of podiatric surgeons in the NHS further increased through the GP Fundholder Scheme which gave those GPs who chose to hold their own budget the opportunity to buy in surgical services from podiatrists working chiefly in private practice, if they so wished. The cost-effectiveness and clinical effectiveness of podiatric surgery represented a means by which GP Fundholders could make best use of their budget. Additionally, they could access a service without the long waiting lists usually found in relation to orthopaedic referral.

A further consideration which influenced the purchasers of podiatric surgery services seems to have been the view that podiatric surgeons could be more proficient at foot surgery than orthopaedics.

> If you look at the general surgery that doctors do, how do they become surgeons? They work with other surgeons and they develop their skills. But they actually get their practice from doing it. I think if you've got a podiatrist who's done 300 small toe procedures, I would rather have him or her than an orthopaedic surgeon who does them once a year.
>
> (Key Informant, Borthwick 1997)

By 1991 podiatric surgery had become sufficiently established in the NHS to prompt the RCS to instigate an inquiry into the provision of foot surgery. The Commission on the Provision of Surgical Services (COPSS) was an inquiry ostensibly intended to improve NHS provision of foot surgery through increasing the co-operation between specialists dealing in foot problems. Both the Podiatry Association and the Society of Chiropodists were represented in this enquiry. Borthwick (1997) contends that this was part of a strategy by the medical authorities to control podiatric surgical practice when it accepted that elimination was not possible. If this view is correct it complies with Willis' (1994) theory of maintaining domination through incorporation. However, a more cynical view put to me by a prominent podiatric surgeon who was a key participant in the COPSS inquiry, was that the intention of the RCS was to absorb podiatric surgeons in order to eventually close down their practice altogether.

The conclusion of the COPSS inquiry gave strong support to podiatric surgery, stressing its cost-effectiveness, clinical effectiveness and high levels of both patient and GP satisfaction. However, the BOA refused to ratify the report and this was shortly followed by similar refusal from the Council of the RCS despite attempts by the President of the RCS to gain approval for publication (Gilbert, 1995). The Podiatry Association decided to

publish the document as a minority report but was forced to withdraw under threat of legal action by the RCS and BOA.

The BOA was prompted to issue a statement which did demonstrate a marked change of attitude from its 1981 statement which had directed its members not to associate with podiatric surgeons. The 1995 statement explained that it was up to the individual surgeon if he or she wished to collaborate with podiatrists but it also implied that important GMC regulations and RCS directives could be breached in any such relationship. The statement also noted alleged harassment of podiatrists by orthopaedic surgeons which it did not condone (BOA, 1995).

With the issue of podiatric surgery unresolved by the failure of the COPSS inquiry to reach any form of agreement, the RCS and BOA sought to enforce their authority through the power of their Royal Charter. Assuming they had the right to 'govern' surgery in the UK they approached the Privy Council for clarification. What they found was a misconception on their behalf; the Royal Charter gave them only the right to 'promote' surgery, the significance being that they could control the training and standards only of their own members (Borthwick, 1997).

Failing to prevent an increasing number of NHS authorities from employing podiatric surgeons, the orthopaedic bodies attempted further obstruction by challenging the use of the terms 'surgeon' and 'consultant'. It was claimed that a podiatrist using the term 'surgeon' would contravene the 1983 Medical Act by 'wilfully and falsely' pretending to be a registered medical practitioner. Legal advice to both sides was that, providing the term was prefixed appropriately, that is, podiatric surgeon, its use may be defendable (GMC, 1995). However, neither side put this to the test and, in any case, the Podiatry Association advised its Fellows to use the term 'Specialist in Podiatric Surgery' rather than 'podiatric surgeon'.

When the BOA claimed that only GMC members could be appointed to NHS Consultant posts (BOA, 1999) advice was sought from the Department of Health who found no objection to the terms 'Podiatric Consultant' or 'Consultant Podiatrist'; as independent organisations NHS Trusts could offer any such post, subject to normal employment law (Department of Health, 1997).

With the failure to block the use of these titles, BOA attention turned to the question of 'Informed Consent'. It was claimed that patients were being misled into believing they were receiving treatment from the medically qualified when agreeing to undergo surgery with a podiatrist; this issue was raised in two separate BOA statements (BOA, 1996, 1999). The Society of Chiropodists and Podiatrists responded with their own statement which explained that 'Every effort is being made and will continue to be made to ensure the public is left in no doubt as to the status of the podiatric surgeon' (SOCP, 1999)

When the BOA attempted to dissuade GPs from referring patients to podiatric surgeons, inferring that risks were being taken by transferring responsibility for patients (BOA, 1996, 1999), their argument held little weight. The GMC had confirmed in correspondence to the Podiatry Association in 1996 that it considered it proper for doctors to refer to podiatrists; it was not incumbent on doctors to 'take responsibility for the clinical activities of other health care professionals, but only for the management of the patient's care' (GMC, 1996).

In 1994 the Department of Health demonstrated its approval for podiatric surgery when it published 'Feet First – Report of the Joint Department of Health and NHS Chiropody Task Force'. This document endorsed podiatric surgery and even stated that 'operative footcare can be cost-effectively provided by chiropodists trained in surgical podiatry (who should work in close association with orthopaedic surgeons but have their own distinct professional contribution.)' (Department of Health, 1994). This document was

published before the failure of the COPSS inquiry and the last point regarding collaboration seems to have gone unheeded by the orthopaedic authorities.

In the years following the COPSS inquiry podiatric surgery gradually became more established within the NHS and by 1999 the service was to be found in more than 40 NHS Trusts (SOCP, 1999). Orthopaedic Surgeons continued to obstruct its development by the denial of support facilities such as hospital admission rights and the use of general anaesthesia (Borthwick, 1999b). Despite these obstructions Borthwick concluded:

> Podiatric surgery .... became highly successful under the NHS reforms. It was at this level that medical dominance was challenged by podiatry, and blunted. NHS management facilitated the establishment of podiatric surgery within the NHS, justified by criteria which its medical opponents failed to undermine.
>
> (Borthwick, 1997:321).

3.7 The Labour government and future opportunities

The story does not end with Borthwick's comment which suggests a victorious result for podiatric surgery. Whilst the 1990s saw podiatric surgery gain a significant foothold in the NHS, they also saw a change of government which brought mixed fortunes for both podiatric surgery and for the concept of medical dominance. Whilst Conservative leader Margaret Thatcher had sought to break professional monopolies which were resistant to market forces, Labour leader Tony Blair preferred the use of direct state intervention to improve the quality of health-care. This was to be done in a variety of ways which included increasing accountability, transparency and consistency across the health professions, and reducing demarcations between professional groups in the interests of efficiency; this also involved an emphasis on multi-professional education for all health workers and served to question the future of the traditional hierarchies in health-care (Allsop and Saks, 2002).

Whilst this latter point, in particular, may suggest the possibility of beneficial opportunities for the advancement of podiatric surgery in the NHS, it was somewhat undermined by the rapid dismantling of the GP Fundholder scheme following Labour's election in 1997. Whilst there were still opportunities for new podiatric surgery ventures within the NHS, the favourable climate created by the direct commissioning of services by GPs was removed; this had even greater relevance for those podiatric surgeons who operated independently outside the Health Service but who had enjoyed the benefit of contracts with GP Fundholders. However, encouragement could be drawn from successive statements from the Department of Health which declared that the government is 'committed to extending the roles which allied health professions play in health and social care, ensuring that they can use their skills flexibly and creatively to the benefit of the patient' (DOH, 2000a:5). This flexibility in the division of labour was also set out in The NHS Plan (DOH, 2000b) and is designed to improve cost-effectiveness and improve patient safety (Price, 2002).

In its second term of office the Labour government embarked on a reform of the health professions, for example, the reform of the GMC (DOH, 2001a), and the creation of the HPC described earlier (DOH, 2001b), the effects of which on podiatry generally have still to be determined. At the time of writing, however, there is apparently encouraging news for the future of podiatric surgery in the NHS. The latest statements from the Department of Health herald a return to the benefits of GP Fundholding albeit in a rather different guise and under a different name. 'Commissioning a patient-led NHS' (DOH, 2005) and 'Health Reform in England: update and commissioning framework' (DOH, 2006) announce reforms which will give the power to contract podiatric surgeons working within the NHS or independently, back to GPs; instead of GP Fundholding the new scheme will be termed Practice Based Commissioning and is likely to involve the formation of

purchasing conglomerates from several individual GP practices. The reforms announced in these recent DOH documents are scheduled, at the time of writing, for implementation between 2006 and 2008.

I have described the development of podiatric surgery and its introduction as a speciality into the NHS in the face of opposition from the main orthopaedic bodies. Opinion amongst individual orthopaedic surgeons regarding podiatric surgery will be considered in Chapters 6 and 7 but it is clear that the formal orthopaedic organisations have objected to the emergence of podiatric surgery and its intrusion into an area of health-care which was previously the exclusive domain of the orthopaedic surgeon. In the next chapter I prepare for the results of my research by considering possible explanations for this opposition.

Chapter 4
Possible Explanations for Resistance Towards Podiatric Surgery

Following the historical evidence examined in the previous two chapters, I now turn to a consideration of possible explanations for the resistance to podiatric surgery by orthopaedic surgeons. In order to do this I follow a format devised by Saks (1995) when considering resistance to the establishment of acupuncture by the medical profession. In using his work for comparative purposes there are key differences between acupuncture and podiatric surgery which should be noted: firstly, acupuncture has always been an 'alternative' to orthodox medical treatment whereas podiatric surgery has not been regarded as 'alternative medicine'. Although podiatric surgery often demonstrates a clearly different approach to orthopaedic surgery, orthodox general surgical principles consistent with those utilised by orthopaedic surgery, are adopted. Secondly, acupuncture has a longer history of development in Britain; Saks studied the application of acupuncture from the early nineteenth century whereas podiatric surgery has only featured as a therapy since the 1970s. Thirdly, unlike podiatric surgery, acupuncture was never practised exclusively by the non-medically qualified. Both acupuncture and podiatric surgery have, though, faced resistance by certain factions of the medical profession. Therefore possible explanations for the causes of resistance to acupuncture have utility for the current study.

Saks initially considered six reasons for non-acceptance of acupuncture which could equally apply to podiatric surgery. They are:

(1) Lack of diffusion of knowledge amongst the medical community;

(2) Non-effectiveness of the therapy;

(3) Considerations of safety;

(4) Problems of research;

(5) Conflicting philosophies of medicine;

(6) The dangers of quackery.

4.1 Lack of diffusion of knowledge

Saks, citing Duncan (1974), says that "scientific resistance to new ideas often derives from a lack of knowledge of the discovery in question" (Saks, 1995:141). In the case of podiatric surgery I felt that a lack of knowledge regarding podiatric surgery techniques amongst orthopaedic surgeons was unlikely to be a cause of resistance. It is true that techniques do differ between the two disciplines and probable that members of each discipline will consider their own techniques superior. However, these differences essentially concern subtleties that were unlikely to explain widespread opposition. It was possible, though, that a certain amount of ignorance existed amongst orthopaedic surgeons about the scope of practice of podiatric surgeons and my data collection sought to quantify this. The results are considered later in Chapter 7.

4.2 Non-effectiveness of the therapy

Orthodox medicine requires controlled trials as evidence of effectiveness. The personal interviews with orthopaedic surgeons would later reveal that some felt there was a need for clinical trials to prove the worth of podiatric surgery. However, they were clearly unaware of trials conducted and results published. Ariori (1989), Tollafield (1993), Hood et al (1994), Tollafield and Parmar (1994), Turbutt (1994), and Vohra (1995) revealed results of clinical audit that were favourable towards podiatric surgery. Helm and Ravi (2003) made a direct comparison with orthopaedic surgery when assessing the views of GPs regarding podiatric surgical results and found that podiatric surgery was strongly preferred. As these are examples of audits published in podiatric journals or, in one case at least, a journal

heavily slanted towards podiatry, it may be that such accounts would escape the attention of orthopaedic surgeons. As such, this may be a further example of a lack of diffusion of knowledge amongst the medical community. However, there are other examples of audit published in journals of wider circulation. Laxton (1995), for instance, published in the *Journal of Public Health* the results of clinical audit which also compared orthopaedic with podiatric surgery and, again, the results were favourable to podiatry. Turbutt (1992) reported favourably on the introduction of a podiatric day case surgery unit in Bedfordshire in the *Journal of One Day Surgery*.

4.3 Considerations of safety

There is a surgical adage which says that the only surgeon who has no surgical complications is one who performs no surgery! Kilmartin (2001) reviewed activity, outcomes, complications and patient satisfaction in a podiatric surgery unit over a 4 year period. He concluded that podiatric surgery was both effective and safe.

Klenerman (1991), in arguing the superiority of orthopaedic surgery, indicated that a podiatric surgeon's knowledge base was unacceptably narrow. In 2004 Kilmartin et al explained that the training programme for a podiatric surgeon was subject to quinquennial review, and announced the latest improvements to the programme. The scheme outlined, revealed the extent of the training programme, its link to university accredited pathways, and served to repudiate Klenerman's claims of a lack of breadth in a podiatric surgeon's training. With evidence of clinical outcomes such as that supplied by Kilmartin (2001) and high standards imposed on the training of podiatric surgeons, concerns for safety seem to be unfounded.

4.4 Problems of research

Modern orthodox medicine has little regard for empirical forms of treatment. Indeed, the current demand for 'evidence-based practice' (Allsop, 2002) means there is a need for all forms of health-care to demonstrate the presence of an appropriate research base. The establishment of a research tradition in podiatric surgery is relatively new and, in formal research terms, can be traced back to the advent of podiatry degrees in the late 1980s. With the acceptance of all Schools of Podiatry into university institutions during the 1990s the significance of research for podiatry grew. Podiatric surgery, once heavily dependent on American literature, can now claim to have its own significant literature resulting from serious research. The Foot, a publication by Churchill Livingstone, and the British Journal of Podiatry are refereed journals which feature the results of podiatric surgery research.

Whilst it is clearly inappropriate to claim podiatric surgery does not have a research base it may well be that lack of familiarity with podiatric journals amongst orthopaedic surgeons leads to the assumption that research is lacking.

4.5 Conflicting philosophies of medicine

Saks compared Western and Chinese medicine in describing cultural differences which resulted in differing philosophies and, again, cited Duncan (1974): 'Cultural dissonance and lack of paradigm conformity are commonly cited as reasons for the rejection of innovations in scientific and other fields' (Saks, 1995:153). I do not believe it is appropriate to claim that 'cultural dissonance' exists between orthopaedic and podiatry surgery even though the latter's origins lie in American society. However, it is fair to say that different paradigms are followed, hence my earlier reference to differing approaches between orthopaedic and podiatric surgery. Underpinning the practice of podiatric surgery is the concept of podiatric biomechanics which podiatrists claim provides them with an in-depth understanding of the

foot as a functional unit. Orthopaedic surgery, on the other hand, has been open to claims that it provides aesthetic correction for deformities without necessarily appreciating the requirements of underlying foot function (Borthwick, 1999). It would later become clear from the personal interviews with orthopaedic surgeons that they refute this accusation of an inferior understanding of the foot function and, indeed, level a similar claim against podiatrists. It would seem, then, that different philosophies may be one reason for the rejection of podiatric surgery by orthopaedic surgeons and this possibility will be further explored in Chapter 7.

4.6 The dangers of quackery

This amounts to a fear that the practice of surgery by the medically unqualified could endanger the public's health. Freidson comments:

> (It) ....is quite natural for people who have developed commitment to their work, they are likely to be suspicious of the value of all that lies outside their domain, including the competence and ethicality of those working outside.
>
> Freidson (1970:150-151)

I believe that any such fear, in this case, is unjustified because of the depth of training of podiatric surgeons and the high standards demanded by the accrediting professional organisation. Official bodies have supported this view by endorsing the practice of podiatric surgery. In 1994 'Feet First – Report of the Joint Department of Health and NHS Chiropody Task Force' (Department of Health, 1994) commended the practice of podiatric surgery. Its key conclusions were that 'Purchasers should review their arrangements for the purchase of ambulatory foot surgery in the light of the services available from chiropodists with specialist post-basic training in surgical podiatry' and 'Continuing professional development should be encouraged and taken forward alongside the promotion of specialist skills training, especially in the areas of diabetes and surgical podiatry'. The King's Fund

(1997) examined both clinical audit and cost-effectiveness of podiatric surgery which also served to confer credibility. It is reasonable to conclude, therefore, that any concerns amongst orthopaedic surgeons with regard to podiatric surgery and 'quackery' are unfounded. Nevertheless, if such concerns exist they could be a cause of orthopaedic opposition to podiatric surgery.

4.7 Professional self-interests

Having considered, and dismissed, the previous factors as reasons for the rejection of acupuncture by the medical profession, Saks (1995) concluded that medical policy was shaped, in this instance, by professional self-interests. Wardwell (1976:63) argues that the most serious threat to the privileged position of the contemporary medical profession is presented by outsiders who "challenge some of the basic assumptions of orthodox medicine and attract patients with a wide variety of conditions". Podiatric surgery does not necessarily challenge orthodox medicine in this way. It does, as earlier explained, follow orthodox surgical conventions though its knowledge base differs from that of orthopaedic surgeons and many of the techniques it employs also differ. The significance of a knowledge base should be noted. In order to successfully exclude competitors from the market for services it is necessary to justify a knowledge base which is scientifically based yet sufficiently complex to ensure that mastery of it is denied to others (Turner, 1995). Indeed, professional status is partly maintained by persuading the public that professional knowledge is unique and effective; it is essential, then, that the profession retains control over that knowledge (Pilgrim and Rogers, 1993).

Podiatric surgery has certainly shown that the knowledge of the orthopaedic foot surgeon is not unique. Furthermore, many assumptions regarding foot function and methods of surgical correction have been challenged. In a relatively short space of time an

alternative knowledge base has been created, albeit one which shares many features of the knowledge base of the orthopaedic surgeon. But the exclusivity of a knowledge base is crucial and when acupuncturists caused that of the medical profession to be questioned they posed a threat to the 'wealth, status and power of doctors' (Saks, 1995).

Professional self-interests – essentially wealth and status – were elaborated upon by Parkin (1971) who argued that power is the key to their distribution; to speak of power, in fact, is simply another way of describing the distribution of material and social rewards. An important method of creating and maintaining this power is to make scarce the amount of skill exercised by an occupation, that is, to utilise the principle of 'supply and demand' to its advantage. This involves restricting the number of entrants to the occupation by imposing stiff entrance qualifications and insisting on long and expensive periods of training, much of which, Parkin argues, is actually of little practical value and is simply a device for restricting the supply of labour. Following this argument, the possibility of a 'new' profession entering the field of foot surgery would have appeared a daunting prospect for orthopaedic surgeons. Could a threat to the self-interests of the orthopaedic surgeon be the reason for resistance towards podiatric surgery? In Chapter 7 I return to the possible explanations considered here for orthopaedic resistance to podiatric surgery and re-examine them in the light of my findings, which follow after the next chapter which describes the research methodology.

Chapter 5
Research Methods

In the previous chapters I described the background to the current study and established my rationale for undertaking this investigation. In this chapter I explain my choice of research design and the methods selected to implement it. I provide an account of the application of the chosen methods including a description of the obstacles I had to overcome to successfully gather my data. I paint a picture of a process of data collection which I found, at different times, to be exciting, frustrating, challenging, but ultimately satisfying; I should also confess that I sometimes felt personally affronted by some of the hostile responses I encountered from certain orthopaedic surgeons. I conclude by describing the analysis of the collected data which involved manual coding and the application of statistical tests using a SPSS computer programme. Issues of validity, reliability, and ethics are considered within the account.

5.1 Designing the research

According to Le Compte and Preissle (1993:30) research design involves focusing clearly on the research question(s) and then asking:

> What information most appropriately will answer specific research questions, and what strategies are most effective for obtaining it?

At the design stage my aim was to research two professional bodies, the Fellowship of the BOA and the Surgical Fellowship of the Society of Chiropodists and Podiatrists. In order to address the research question I set out my objectives as follows: firstly, with regard to the orthopaedic surgeons, to gather information on their views on podiatric surgery. Secondly, with regard to the podiatric surgeons, to gather information on their views on

orthopaedic surgeons, and to explore the extent of alleged opposition podiatric surgeons had encountered from orthopaedic surgeons. Thirdly, to explore any willingness amongst both orthopaedic and podiatric surgeons to promote co-operation between the two disciplines. Finally, to discover any areas of the inter-disciplinary relationship of which I was unaware.

The way in which these objectives relate to my professional status is worthy of explanation. As a practising podiatric surgeon of some ten years experience I had occasionally encountered attempts by orthopaedic surgeons to obstruct my practice. One example came when I attempted to gain consultation rights at a local private hospital; on application to the Hospital Manager I appeared to be 'welcomed with open arms'. However, when my application reached the Management Advisory Committee, on which orthopaedic surgeons were heavily represented, my request for theatre privileges was refused although I was offered the much less beneficial privilege of renting an outpatient consulting room. In my view, the reasons given for this refusal were spurious and I was convinced that this was the result of orthopaedics intervention.

In addition to my personal experiences I had heard many anecdotal reports of widespread conflict between orthopaedic and podiatric surgeons on a national basis. In terms of the current research I was, therefore, in a somewhat privileged position in already having a 'feel' for the prevailing attitudes amongst podiatric surgeons towards orthopaedic surgeons as a result of alleged obstruction. However, it was necessary to establish the level of any professional animosity and not rely on anecdotal evidence. It was also important that the research was not inappropriately directed by any bias I held and that areas of professional co-operation between the two disciplines and willingness to interact were explored. With regard to the issue of bias, I refer the reader back to the introductory chapter where I discussed the 'personal perspective'. Here, I explained that the stimulus for

undertaking this study came partly from dissatisfaction with my experiences with orthopaedic surgeons. These interactions *have* influenced my attitudes towards orthopaedic surgeons and I must, therefore, admit a bias. However, I did not undertake this study in order to 'strike a blow' for podiatric surgeons, but to attempt to explain why conflict has arisen and, if possible, to offer suggestions about how this conflict could be resolved. I therefore determined, at the very start, to approach this study with an open outlook and not to allow my previous experiences to affect either the collection of data or their interpretation. As I go on to explain later in this chapter, I undertook to maintain some degree of impartiality by using reliable research instruments which were intended to ensure that all subjects were approached in the same way and were asked the same questions. Nevertheless, I could not deny that I was a researcher investigating a situation in which I was also an actor. In light of this I now turn to a consideration of what is commonly referred to as the autobiographical approach.

5.1.1 Auto/biography

As I noted in Chapter 1, there is a growing body of work using an auto/biographical approach and this challenges the more traditional methods which seek to be objective by placing the investigator outside the research process; he or she would be an observer, not a participant. For some, however, the 'self' has always been prominent in sociological writing; although it may have been ostensibly restricted to prefaces, acknowledgements, and so on, in reality traces of 'self' permeate all forms of writing (Anderson, 2001). As a more open form of expression it is claimed that using 'I' takes responsibility for what is written whereas, by using 'we', such responsibility is somewhat negated (Morley, 1996, cited in Letherby, 2003; Ellis and Bochner, 2000). Writing in the first person also allows the use of personal anecdotes to illustrate points and the personal touch can sometimes help

in presenting difficult and personal life-changing material (Frank, 1995; Ellis, 1991, 1999; Ettorre, 2005, 2006; Katz Rothman, 2007).

But this question of writing style or presentation is part of a more involved issue which is often referred to as 'the researcher as insider or outsider'. Generally, the 'outsider' researcher is considered to follow the traditional methods referred to previously when investigating a group of which they are not a member (though this does not preclude auto/biographical application, that is, acknowledging the researcher's views, prejudices, and so on, regarding the research subject). In contrast the 'insider' researcher, more in keeping with auto/biographical principles, examines a group to which they belong. Leaving aside the views of those who regard this distinction as too simplistic and who feel the researcher's role is better conceptualised as on a continuum rather than as an either/or dichotomy (Le Gallais, 2003; Breen, 2007), both advantages and disadvantages of researching as an 'insider' have been identified.

With regard to advantages, the 'insider' researcher is likely to have easy access to the group to be researched and not be subject to the vagaries of 'gatekeepers' (Breen, 2007). My own experiences with data collection illustrate this clearly. As I explain later in this chapter, whilst I had no difficulty in accessing my own group, podiatric surgeons, the most demanding aspect of the entire research project was overcoming the obstacles presented by a 'gatekeeper' in order to access a group to which I was an 'outsider', that is, orthopaedic surgeons.

The 'insider' researcher will have a more nuanced understanding of the group's culture than an outsider. S/he will have knowledge of past and present climates, and this will increase the capacity to interact more comfortably with the group and lead to the possibility of enhanced rapport between informant and researcher (Hockey, 1993; Bonner and Tolhurst, 2002). Enhanced rapport can lead to greater disclosure because the informant

may be more inclined to 'open up' to someone s/he feels is empathetic and shares membership of the same group culture (Hockey, 1993).

This familiarity with the group can 'smooth' the interview process; because the researcher is a party to the nuances and idioms within the language group, and because non-verbalised answers may be conveyed with hand gestures or facial expressions, short-cuts may be available to interpret situations (Schutz, 1976; Johnson-Bailey, 2001). The researcher may have insights and sensitivity to things both said and unsaid as a result of their familiarity with the culture of the group (Hockey, 1993). This sensitivity may make data collection easier because the researcher may understand how best to ask critical questions, successfully gathering information without causing offence (Ntseane, 2001).

In terms of disadvantages of 'insider' research, these are often seen as opposite arguments to perceived advantages. For example, group access ought to be readily available to a group member but this can be subject to both contextual and cultural factors which can sometimes make access more difficult for the 'insider' researcher (Johnson-Bailey et al, 2001). Familiarity with the group can also cause problems; there can be a loss of objectivity particularly in terms of inadvertently making erroneous assumptions based on the researcher's prior knowledge and experience (Robson, 2002; Breen, 2007). For some, this threat to objectivity is critical (Fontana and Frey, 1994) whilst others regard it as less so, believing that full objectivity is never possible when successfully pursuing qualitative research (Hubbard et al., 2001).

Familiarity may also present problems for data collection. The informant may assume the researcher already knows the answers to the questions and may not offer the information required or, at least, may provide a truncated version (Breen, 2007). In some instances probing for information of which the informant knows the researcher is already cognisant can cause aggravation (DeLyser, 2001). The use of non-verbal communication

may create short-cuts and facilitate a fluent interview but it can also cause difficulty when examining the resultant transcript as little information may be evident (Kanuha, 2000).

For my data collection from podiatric surgeons I experienced few of the disadvantages of the 'insider' researcher because my research instrument was a questionnaire and I did not employ personal interviews. As I noted earlier, I met few problems with access and I explain later in this chapter that I achieved a good response rate with my questionnaires. In the next section I explain my reasons for not interviewing podiatric surgeons and, although my reflections in Chapter 7 question the wisdom of this, by not conducting interviews I did avoid certain problems such as those involving non-verbal communication or a lack of information provision because of assumptions about my knowledge levels.

The auto/biographical style of research does, however, have its critics. In addition to concerns about a lack of objectivity, some regard the style as 'un-academic' indulgence and sloppy intellectual work (Atkinson, 1997; Letherby, 2003, citing Katz Rothman, 1986, Scott 1998, Letherby, 2000). Payne (2007) is sceptical of auto/biography and cautions that 'disclosure' is not in itself a guarantee of enhanced validity. He also questions how much confidence can be placed in one insider's assessment and interpretation of the situation in which they find themselves.

Apart from these general criticisms there are certain assertions against which my research approach can be examined. According to Letherby,

> there is recognition among social scientists that we need to consider how the researcher as author is positioned in relation to the research process: how the process affects the product in relation to the choice and design of the research, fieldwork and analysis, editorship and presentation
>
> (Letherby, 2003:8)

This view is supported by Plummer (1983) whom I quoted earlier as describing the researcher as a 'constructor of knowledge'.

Throughout this dissertation I make frequent references to my status as a podiatric surgeon, often using this to explain my feelings or actions at certain stages of the research process. In this way I offer frequent reminders to the reader of my 'insider' status. It is perhaps, though, more in the interpretation of the data where the 'insider'- as- researcher approach could be questioned or, at least, examined. The reader will draw their own conclusion on how much my status has affected data interpretation and I hope my reflections in Chapter 7 will help in their deliberations.

5.2 Methods of data collection

With regard to orthopaedic surgeons, my objectives were somewhat less specific than those relating to podiatric surgeons. I decided to start with a 'blank canvas' and investigate views towards podiatric surgery in general, and not to start with the assumption that the prevailing attitude was negative, in other words, my attitude was not to be influenced by hearsay from among my peers. In order to build a comprehensive picture of the orthopaedic viewpoint I would need to explore attitudes in some depth. It was this consideration that led to the adoption of two methods of data collection, firstly, a questionnaire survey of practitioners' views and, secondly, in-depth interviewing of a sub-sample of the surveyed respondents.

This approach to data gathering from the one source was acceptable as factual or relatively straightforward issues are best dealt with by questionnaires whilst semi-structured interviews are more appropriate to address complex or in-depth questions (Gillham, 2000). When more than one method is used to gather information from the one source this is termed triangulation (Flick, 1998). Brewer and Hunter (1989) assert that all social science research methods have their own strengths but also their own flaws; when

using more than one method it is argued that the strengths of one may overcome the deficiencies of another. With this in mind, it is also argued that the use of triangulation may serve to provide an in-depth understanding of the phenomenon in question (Denzin and Lincoln, 2000). Although triangulation was once seen as a strategy for validating results obtained from individual methods, it is now argued that it is less a means of validation and more a way to 'increase scope, depth and consistency in methodological proceedings' (Flick, 1998:227).

The strengths of questionnaires are described by Sarantakos (1998) who claims they are a 'stable, consistent and uniform measure, without variation'. Sarantakos continues that questionnaires can

> offer a considered and objective view on the issue since respondents can consult their files (or other sources for factual confirmation before completing the questionnaire) and since many subjects prefer to write rather than talk about certain issues
>
> (Sarantakos, 1998:224)

Questionnaires also have the advantage that they reduce the possibility of bias or errors resulting from the presence of an interviewer (Sarantakos, 1998; Shuy, 2001).

Oppenheim, (1992) compares the merits of questionnaire survey to those of face-to-face interviewing. It is argued that questionnaire surveys may have the disadvantage of:

- generally low response rates and consequent biases;
- no opportunity to correct misunderstandings or to probe;
- no control over the order in which questions are answered, and no check on incomplete responses, incomplete questionnaires or the passing of questionnaires to others.

In effectively confirming Brewer and Hunter's (1989) assertion that the strengths of one method of data collection may address the weaknesses of another, Oppenheim claims face-to-face interviews provide:

- higher response rates;
- the opportunity to correct misunderstandings;

- the facility to control for incompleteness and for answering sequences.

The disadvantages of interviews – time consuming to conduct and process, potentially a higher risk of interviewer bias, and usually too expensive to reach a widely dispersed sample – are overcome by the advantages of questionnaire survey (Oppenheim, 1992).

With the advantages and disadvantages of the two data-collection methods considered, then, it was decided to research orthopaedic surgeons firstly by questionnaires to gather a breadth of information and to follow this with interviews in order to gain a more in-depth understanding of issues which might arise from the questionnaires.

With regard to data collection from podiatric surgeons, the possibility of adopting the same methods of data collection as those used with orthopaedic surgeons, that is, questionnaires and in-depth interviews, was considered. However, it was questionable whether the time and effort involved in conducting interviews was outweighed by the potential benefits from interviewing a sample from a population to which I belonged. It was my 'insider' status among podiatric surgeons that persuaded me to rely on data collected from questionnaires only. As an 'insider' I was well acquainted with podiatric surgeons' attitudes towards orthopaedic surgeons. I first became aware that animosity existed between the two disciplines when I began my surgical pupillage in 1993. Apart from interaction with my surgical tutors, I also mixed professionally and socially with other surgical pupils and also with other qualified surgeons who would regularly visit our surgical centre for purposes of up-dating. As a result I gradually became 'immersed' in the orthopaedic-podiatric 'conflict'. By the time I came to design the current research project this exposure to attitudes among podiatric surgeons had increased through time spent practising in both the NHS and private sectors, regular attendance at national and regional conferences, professional study days, social events, regular telephone conversations, and so on, all of which helped me to appreciate podiatric surgeons' views on orthopaedic surgeons. After

data collection from orthopaedic surgeons was complete I realised how much time, energy and expense was involved in conducting personal interviews. I believed that questionnaires would provide sufficient data to confirm that conflict with orthopaedic surgeons did occur and that they would reveal instances where more co-operative relationships existed; I also suspected that the data collected would be rich enough to form an analysis of the overall views of podiatric surgeons regarding orthopaedic surgeons. When these benefits were weighed against the time and resources needed to conduct a further round of personal interviews, it was decided that only questionnaires would be used to gather data from podiatric surgeons. However, in 5.1.1 I noted concerns that the 'insider' researcher may have formed preconceptions about situations affecting his or her group and erroneous assumptions about group members. Whilst the questionnaires should have been capable of gathering much unambiguous data, there was a possibility that I could have formed inappropriate conclusions about deep, emotive reasons behind attitudes held. Therefore, writing now with data collection and analysis complete, and with the benefit of hindsight, it may have been worthwhile to conduct some personal interviews. I return to this matter in Chapter 9 when reflecting on methodology and suggest there are three particular areas where personal interviews may have enriched the data: dealing with orthopaedic opposition, successful attempts at collaboration, and willingness to establish a formal association.

5.3 Questionnaire design – orthopaedic surgeons

The questionnaire to be sent to all Fellows of the BOA was designed with two aims: the first was to gather information on the views of orthopaedic surgeons on the practice of podiatric surgery; the second was to act as a means of contacting orthopaedic surgeons in

order to gain permission to undertake some personalised interviews which would add richness and detail to information gathered from the questionnaires.

At the time of deciding to employ questionnaires, the exact size of the BOA Fellowship was unknown but it was thought feasible that the entire Fellowship population could be reached through this method which further justified it as an appropriate form of data collection. It is explained later in this chapter that gaining access to a Fellowship list proved difficult but, once obtained, the list was found to comprise slightly less than 1600 Fellows; it was therefore possible to target the entire population by way of questionnaires.

General objectives

According to Oppenheim (1992) the pilot work for a questionnaire should begin before any form of question construction. This early activity could involve informal interviews, talks with key informants, or the gathering of essays on the relevant question; from this a 'feel' can be developed for the issues to be explored. In my case, I was already familiar with a range of issues pertinent to the current study because of my experience as a podiatric surgeon. As a result my pre-existing 'feel' for the relevant issues was instrumental in determining what information I should seek to gain by way of the questionnaires. Essentially the questionnaires sought to establish: firstly, the amount of contact the respondent had experienced with podiatric surgery and their level of satisfaction with any surgical results he or she may have encountered. Secondly, how informed the respondent was with the scope of practice of a podiatric surgeon. Thirdly, whether there was a consensus amongst orthopaedic surgeons about the role podiatric surgery has to play within the NHS. Fourthly, whether or not the respondent believed podiatric surgeons should be subject to regulation by an orthopaedic body.

With regard to the amount of contact the respondent may have had with podiatric surgery, anecdotally there was significant opposition towards podiatric surgery from orthopaedic surgeons. Was this justified because the individual surgeon had experienced unsatisfactory interaction with podiatric surgeons or because he or she had met adverse surgical results? Often, I had been informed by colleagues, orthopaedic surgeons would adopt a negative stance towards podiatric surgery without any attempt at personal interaction and without any evidence that podiatric surgery results were unsatisfactory;

Concerning how informed the respondent might be with the scope of practice of a podiatric surgeon, was it possible that, with a lack of professional interaction, orthopaedic surgeons may not understand just what podiatric surgery could achieve and, equally important, the self-imposed limits within which the discipline worked?

Was there a consensus amongst orthopaedic surgeons about the role podiatric surgery has to play within the NHS? Once again, anecdotal evidence informed this question. Colleagues had told me of orthopaedic surgeons who had allegedly threatened to withdraw their patronage of Hospital departments, for example, histopathology, if those departments continued to service podiatric surgery. Were these isolated incidents or was there widespread opposition to the further development of podiatric surgery?

With respect to the issue of whether or not the respondent believed podiatric surgeons should be subject to regulation by an orthopaedic body, Larkin (1983) described what he termed 'the medical division of labour'; through allocating discrete tasks to subordinate occupations, the medical profession maintained overall control of health-care. If orthopaedic surgeons were willing to accept podiatric surgery as long as it functioned under orthopaedic regulation, was this a further application of the 'medical division of labour'?

In addition to these main objectives, the questionnaires also sought to discover information on gender, age, and geographical location of orthopaedic surgeons in order to look for patterns in the profiles of respondents.

Construction and design of the questionnaire

Questionnaire design began after consulting a number of relevant sources on methodology. The length of the questionnaire was important. To encourage as full a response as possible it was necessary to ensure that the initial and overall presentation of the questionnaire was appropriate and precise. At this stage one should consider the length of the questionnaire in relation to the amount of time the average respondent can be expected to devote to its completion (Oppenheim, 1992). In order to create the impression that the questionnaire was sufficiently brief, thereby encouraging completion by respondents, consideration was given to the lay-out of the questions. Questions were arranged to occupy as little space as possible whilst remaining totally legible which was facilitated by attention to font size. The questionnaire was to be presented on light green paper (a traditional operating theatre colour) to maximise visual impact.

The length of individual questions had also to be considered, as long questions are likely to bias responses and should be avoided. Complicating phrases are often ignored by respondents particularly when situated at the end of the question as they may already have initiated their response by the time the phrase is met (Foddy, 1993). A maximum length of twenty words per question has been advocated (Oppenheim, 1992). Generally the questions of the finalised questionnaire complied with this direction with only one full question and one sub-question exceeding it.

The wording of individual questions was considered in order to encourage the

respondents to answer and to avoid ambiguity. With regard to the former, it was necessary not to pose questions which the respondent could regard as threatening or, at least, professionally challenging (Foddy, 1993). For instance, question 8 in the finalised questionnaire (see Appendix 1) sought to establish the understanding of orthopaedic surgeons with regard to the scope of practice of the podiatric surgeon. In the first draft of the questionnaire the question asked 'To your knowledge is podiatric surgery limited to.....(response options)'. This was eventually changed to 'There is sometimes confusion about the areas involved in podiatric surgery. In your view which of the following best describes the current situation?.....(response options)'. In this form the question did not directly challenge or isolate the 'knowledge' of the respondent in the way that the original wording might have.

In terms of ambiguity,

> the greater the number of substantive or informative words used,
> the more likely it is that the question will be interpreted wrongly
> (Molenaar, 1982:55).

Within the context of this questionnaire, the use of 'substantive or informative words' was unavoidable. Furthermore, the population would not involve a cross-section of the public but a specialised group who would be unlikely to misinterpret 'substantive or informative words', most of which would be used widely in their daily working lives. Nevertheless, wording of questions was repeatedly checked throughout the questionnaire drafting and re-drafting process. In the final event, feedback comments from the questionnaires indicated little ambiguity had arisen though there was some disquiet over the use of the term 'podiatric surgery'; one respondent commented that he had started to complete the questionnaire before he realised that the term 'podiatric surgery' referred to surgery performed by podiatrists rather than procedures performed on feet by orthopaedics. Instead of genuine confusion this may have reflected dissatisfaction

evident among several respondents with the association of the term 'surgeon' with podiatrists, an event they claimed to be an oxymoron. In attempting to avoid ambiguity, other considerations were undertaken. Negatives should, where possible, be avoided as they make questions more difficult to interpret. It is also argued that response rates for negative options in ratings scales are perceived as being stronger (Foddy, 1993).

In the orthopaedics questionnaire, questions were posed in a neutral form where possible. However, where insight into attitudes was sought, positive or negative nuances were not only unavoidable but actually desirable, that is, questions were posed in a positive or negative way in order to stimulate a response in the form of agreement or disagreement. So that, overall, neither a positive nor a negative emphasis was created, questions with a positive slant were alternated with those of a negative slant. An example was question 6 which asked about the consequences of greater availability of podiatric surgery within the NHS; 6c was positively phrased:

> 'An increase in the availability of podiatric surgery in the NHS would increase levels of patient satisfaction' (leading to response options),

and was followed by the more negative 6d:

> 'An increase in podiatric surgery within the NHS would result in more cases needing the attention of the orthopaedic surgeon' (also leading to response options).

Question 6 like Question 7, which asked about how the respondent regarded the capabilities and freedom to practise of the podiatric surgeon, was subdivided in order to produce sets of questions. Sets of questions are regarded as more reliable than single questions when measuring attitudes. A single question can suffer from the vagaries of wording and, as such, the answer can be subject to context, emphasis or even the mood of the moment. Sets of questions, on the other hand, will result in a more consistent and

stable measurement of attitude (Oppenheim, 1992).

As indicated earlier, the sub-sections which comprised questions 6 and 7 were answered by means of a rating scale. The scales were identical in each case and involved five response categories labelled 'Strongly Agree', 'Agree', 'Neither Agree nor Disagree', 'Disagree', and 'Strongly Disagree'. These categories are typical of a Likert scale which is widely used to measure attitudes and is regarded as having high reliability and validity (Sarantakos, 1998). Whilst there is debate about how many categories should be employed in a rating scale (Finn, 1972; Andrews, 1984), the suitability of a five-category scale was confirmed by Molenaar (1982) who, having reviewed a number of studies that explored rating scales, concluded that the optimal number of categories was seven, plus or minus two.

The orthopaedic surgeons questionnaire employed both open and closed questions. Open questions allow the respondent a greater amount of freedom of expression; the respondent is able to report what is salient in his or her mind and to reveal complex motivational factors without restriction. Without the direction brought by a closed question the respondent is less likely to be influenced by the researcher. Critics claim that open questions produce answers that are extremely variable, of dubious reliability, and that are difficult to code (Foddy, 1993). Closed questions, on the other hand, produce answers that are much easier to computerise and analyse, and because they allow respondents to answer the same question they produce less variable answers and can be more meaningfully compared. However, closed questions may be open to the format effect, that is, the respondent may endorse the most socially acceptable answer or endorse either the first or the last option presented. As both forms of questions have advantages and disadvantages, it has become common practice to employ a judicious mix

of the two (Foddy, 1993).

The mix of questions in the orthopaedics questionnaire was heavily slanted towards closed questions. Of the eleven questions involved, the first (which asked for descriptive statistics – gender, age, geographical location) and the last (which invited the respondent to take part in a personal interview) can be discounted in a consideration of open/closed questions. Of the remaining nine questions, eight were closed, two employing a Likert scale as described. These questions sought to gather much of the information required to fulfil the objectives of the questionnaire I described earlier. Oppenheim (1992) confirms the suitability of closed questions to gather attitudinal as well as factual information and also readily allow comparisons between groups. He does also caution that closed questions can introduce bias by 'forcing' respondents to choose between given alternatives and making them focus on alternatives they may not otherwise have considered.

Question 10 was the only open question employed in the questionnaire. However, the nature of this question meant that it addressed the imbalance towards closed questions. After the closed question number 9 had asked whether podiatric surgeons should be regulated by an orthopaedic body, question 10 asked "In your view what would be the advantages/disadvantages of such regulation?" After allowing generous space for the response, the respondent was invited to comment further on this or any other topic, with even more generous room for response at the end of the questionnaire. As this invitation was placed effectively at the end of the questionnaire, it meant that any issue the respondent had met earlier in the questionnaire about which they felt strongly, or which they felt restricted in answering because of the closed question format, could now be fully addressed in an unrestricted way, allowing them the opportunity to register their feelings as expressively as they wished. This proved to be most effective; much additional information

was gathered with many respondents taking the opportunity to elaborate on various issues arising from the questionnaire and providing much illumination regarding prevailing attitudes amongst orthopaedic surgeons.

In constructing the questionnaire, issues of validity and reliability were considered. I discuss validity later in this chapter. Reliability – the need for consistency – is mainly about reducing the effect of researcher bias so that the results obtained are not influenced by a variable research instrument or by any 'quirks or improvisations' of the researcher (Arskey and Knight, 1999). There is a need, then, to approach each informant in the same manner and to ask the same questions, in the same way, of them. One of the benefits of questionnaire survey is that it lends itself to this consistency; there is a reduced chance of creating a researcher effect compared to interview investigation (Oppenheim, 1992) and any effect that is built into the questionnaire is at least imposed on all recipients.

Litwin (1995) discusses the reliability of survey research and explains that a certain amount of error will occur in any collection of data; the higher the amount of error that occurs, the less it is appropriate to draw inference from the population studied. Unpredictable error – random error – can be caused by many different factors but is affected primarily by sampling techniques. To reduce the chances of random error it is advisable to select as large and representative a sample as possible. With the orthopaedics questionnaire sampling was not an issue as the aim was to achieve a total sample. The entire population of Fellows of the British Orthopaedic Association was accessible and each would receive a questionnaire. Random error related to sampling would therefore not be an issue. If an acceptable response rate could be achieved, it would be appropriate to draw inferences from the findings regarding the population.

Access

With the format of the questionnaire finalised, the focus now turned to approaching respondents in a way that would encourage positive communication and the completion of as many questionnaires as possible. At the stage of writing my research proposal I was concerned that any approach to orthopaedic surgeons for assistance from a podiatric surgeon would be met with resistance. As I have already indicated, my professional interaction with orthopaedic surgeons in the past had been, at best, indifferent and, at times, had resulted in forms of obstruction. With much anecdotal evidence from colleagues confirming a general attitude of non-cooperation towards podiatric surgeons by orthopaedic surgeons, I feared that my project would never come to fruition; if orthopaedic surgeons provided me with no data my study could not advance beyond the design stage.

At this point, then, I considered the use of a covert approach to gathering data. I felt that if I approached my target population as a research student without any form of background in podiatry, subjects would be more amenable to co-operation and would provide information more readily than if I presented myself as a podiatric surgeon undertaking the research.

However, when I discussed this proposition with my supervisors it was rejected because of ethical considerations. These were: firstly, the true identity of the researcher could easily be suspected or discovered through a detectable familiarity with jargon and technical details. Secondly, discontent with my University could be fostered amongst the local medical community. Finally, there could be contravention of the British Sociological Association guidelines which allow covert investigation only if no other approach is feasible and if successful research conducted in this manner would result in substantial benefits.

With regard to the final consideration, a case for covert research could not be made in terms of the current study as an overt method *was* possible and this *could* yield valid data. In general, covert investigation is not viewed favourably and this is summed up by Bulmer (1982:217) who asserts that it is

> neither ethically justified nor practically necessary, nor in the best interest of sociology as an academic pursuit.

It was therefore decided that an overt method would be used. I would present myself as a research student from the University of Plymouth and any enquiries regarding my podiatry background would be answered openly and honestly. When I eventually embarked on data collection my status did not prove to be problematic; as will be explained later there was no reason to suppose that questionnaire returns were affected as the response rate was acceptable. When it came to the personal interviews I was asked several times about my status as a podiatric surgeon and this resulted in no discernible reluctance to converse freely. On one occasion I was even asked to 'chat' about a podiatric surgeon's training, following the conclusion of the formal interview.

With the research design decided upon, and the use of overt methods firmly established, ethical approval for the study was sought from and granted by the Faculty of Human Sciences, Human Ethics Sub-Committee of the University of Plymouth.

It was decided that respondents would be more inclined to complete and return the questionnaires if their distribution was to be sanctioned by the hierarchy of the BOA. To this end I was to formally approach the BOA and ask for approval for the distribution of my questionnaire. My request would be accompanied by a letter of commendation from my supervisors. Credibility would be enhanced if some form of orthopaedic support for the project could be demonstrated. I had previously enjoyed an academic association with an

orthopaedic surgeon and I approached him with a view to enlisting his support. Without hesitation this support was given in written form.

A telephone enquiry to the offices of the BOA brought the response that the President of the BOA would be the most appropriate officer to contact with a request for approval. I was informed that the membership of the BOA totalled about 2,500 in the UK but individual members' details were not for public scrutiny; however, if the President of the BOA were to be furnished with details of the research project, approval could be sought from the BOA Council and, if this was forthcoming, a membership list could be provided in the form of adhesive labels. I was encouraged by this response: firstly the total number of Fellows of the BOA would be less than the total membership which confirmed it would be possible to approach the total population; secondly the provision of a mailing list by way of adhesive labels would greatly reduce the time and energy to be expended in dispatching the questionnaires.

The current President of the BOA, at that time, was Mr A. He was sent documentation which involved:

- an introductory letter which explained the nature of the research, the significance of the viewpoint of orthopaedic surgeons, and a request for Council approval for distribution of the questionnaire;
- a sample questionnaire;
- a letter of introduction and support from my supervisors;
- a letter from the supportive orthopaedic surgeon.

When no reply had been received from Mr A after two months, a telephone call was made to the offices of the BOA in London. This brought the response that the administration staff had no knowledge of the documentation in question and it was suggested that I contact Mr A's secretary in the east of England for further information.

On phoning her I was informed that the Presidency had now passed to Mr B. However, it was possible that Mr A had the relevant documentation but unfortunately he would be out of the country for some weeks; his secretary promised to investigate. On contacting her again, one month later, it was evident to me that she had not investigated the matter but she did suggest I contact Mr C, a prominent officer of the BOA for guidance.

Mr C was contacted by telephone and initially he seemed helpful; he admitted there were difficulties between the BOA and podiatric surgeons and seemed to think the research project had merit. He requested that a new set of documents be sent to him and explained that he had the power to sanction my necessary assistance. Duplicate documents were duly sent but after a further two weeks had elapsed no response had been received. Telephone calls were placed to his office but it proved impossible to speak to him. After several messages had been left and no replies received, a further call brought a response from Mr C via his secretary. In effect Mr C refused to co-operate because his membership received a great deal of similar requests, most of these were ignored, and consequently he would not wish a false impression to be gained from a low response rate. Faced with this barrier to contacting the BOA Fellowship two actions were undertaken: firstly, a further letter from my supervisors was to be sent to Mr C requesting that he reconsider his decision, and, secondly, the surgeon who had sent a letter of support was to be contacted for his suggestions. The former action was unsuccessful. The supervisors' letter assured Mr C that survey response rates had long been recognised in the social sciences as problematic, but statistical techniques had been developed to compensate for small proportions of returns. Further assurance was given regarding the professional and responsible handling of data gathered. Mr C's reply came more than two months later and reiterated his earlier position.

By this time I was experiencing marked frustration and I was suspicious of the motives behind the resistance I was encountering. The apparent indifference of the BOA staff which greeted my first attempt to ascertain the fate of my original documentation had been followed, initially, by encouragement from Mr C who had then, it seemed, undergone a total reversal in attitude. I felt, at this stage, I was meeting the type of obstruction from the BOA hierarchy which my surgical colleagues, allegedly, had often encountered in the health-care arena.

Fortunately, the response from the supportive surgeon was quite different to any I had received from the BOA. He was not at all sympathetic to the stance of the BOA and explained that their annual report was published in their handbook which also contained the membership list; this document is available to the public as the BOA is both a registered company and a registered charity. An inter-library loan request for the handbook was made, with the British Library suggested as a likely source. This proved unsuccessful when it was found that the book was a reference item and therefore could not be obtained on an inter-library loan. At this stage, desperate to gain access to a mailing list, I was prepared to travel to London and copy the Fellowship list by hand. My local librarian agreed to search further and enquired at the University College Library in Stanmore, Middlesex and at Companies House in Cardiff. Unfortunately the Stanmore library no longer held the handbook while Companies House held only the accounts of the BOA. As a last resort before travelling to London I, once again, contacted the supportive orthopaedic surgeon. A request for his own personal handbook had never been made because of an unwillingness to place him in a compromised position. However, when he heard of my predicament he volunteered his own copy and dispatched it by post immediately. With the BOA handbook providing a mailing list for its Fellowship, the questionnaires were despatched, together with an accompanying letter

and a return envelope, but without any form of BOA approval. The initial mailing was repeated to those who failed to respond and this, in turn, was followed by a third mailing as necessary.

'Gatekeeping'

Before considering further issues relating to the orthopaedics questionnaires I feel it worthy to elaborate on the problems I faced from professional 'gatekeeping' especially as these problems nearly brought about premature termination of my research project. Some time after successfully despatching the questionnaires I decided to explore the question of gaining access to a bureaucratic organisation, as much as anything to learn if there was a way I could have made my approach successful.

Ostrander (1995) gives some advice on this subject: firstly, one should start at the top, that is, the head of the organisation should be approached. Although I had failed to contact the President of the BOA, the official I dealt with did hold a senior position. At this stage I appeared to be dealing with a monocratic bureaucracy, that is, an organisation subject to a single chain of command; I gained this impression from an assurance that the official I was negotiating with had the power to authorise my request. This, however, proved not to be so. I suspect that the official concerned, although possibly holding nominal authority, elicited the opinions of others on the wisdom of supporting my application. The consensus would have been that it was an unwise decision and so my application was denied – thus indicating I was dealing not with a monocratic bureaucracy but with collegial control (Murray et al, 1983).

Secondly, be prepared for negotiations by having a research proposal available. Thirdly, be clear of your rationale, your goals, your methodology and be prepared to state

your credentials. My introductory letter effectively covered these points although a full research proposal was never presented. The proposal did, however, have the full credibility of university support. Fourthly, offer to provide a copy of the final report having first stressed that full confidentiality and anonymity within this is assured for subjects involved. This, again, was covered in the letter of introduction. Finally, beware: some may want to 'review and comment', that is, edit your final report which can jeopardise the integrity of the research and researcher. At least the refusal of the BOA to co-operate spared me the necessity of dealing with the possibility of this last obstacle. Ostrander concludes that, despite having well thought-out strategies, gaining access may well be down to luck and a willingness to take opportunities when they are presented. Essentially this is how I gained access, by taking advantage of a 'back-door' opportunity though, as I have explained, this was not in any way unethical and I felt justified in using this approach when I believed the BOA 'gatekeeper' had been less than sympathetic to me.

What I also believe is that adopting any other approach would have been unlikely to bring greater success. The BOA is a large bureaucratic organisation which has been formed by members for the benefit of members. The aims of this Association are to sustain interests among its members and protect them from outside interference. Prominent amongst those interests are wealth, power, and prestige. Their resources are no doubt vast and, as an organisation, the BOA will enjoy a certain amount of political influence. It will, therefore, be extremely difficult for an outsider to penetrate the wall of protection that exists around the organisation if the 'gatekeeper' denies access. Johnson (1972:54) warns that, in such an organisation, 'the community identity of the occupation is threatened by divergent interests and "missions".' I, no doubt, appeared to the BOA to have a 'mission' and, although I had no political force and stood, essentially, as a lone outsider, I seem to

have been denied access on the grounds that my enquiries could have threatened the interests of members.

Alternatives to piloting

Questionnaires are traditionally piloted before despatch to the target population (Oppenheim, 1992; Sarantakos, 1998; Gillham, 2000). The benefits of piloting chiefly lie in devising the actual wording of questionnaires so that ambiguities are excluded, but a disadvantage is that it is not uncommon to 'use up' several hundred respondents in pilot work (Oppenheim, 1992). There is a difference between trialling and piloting a questionnaire. Trialling involves trying out the questionnaire on a different, though similar, population whilst piloting involves experimenting within the actual setting, that is, with a sub-group from the actual population to be sampled (Gillham, 2000). Trialling is advocated when piloting is difficult. When a total population is 'very small and highly specific' so that one cannot afford to 'use up' the numbers involved in a pilot group, alternative samples should be considered who are comparable in their knowledge and outlook (Oppenheim, 1992). It was decided not to pilot the orthopaedics questionnaire because of a concern regarding response rates. Although the target population (Fellows of the BOA) was fairly high at over 1,500, as earlier explained, my a priori experience as a podiatric surgeon led me to erroneously believe that the response rate from orthopaedics would be poor; as a result a sub-group could not be 'sacrificed' in a pilot study. Trialling was not a viable alternative. Because the target population was highly specific, and the questions of which the questionnaire was composed were context-specific, it would not have been appropriate to trial this questionnaire on any other group.

In order to achieve the perceived benefits of piloting without jeopardising the

possibility of gaining an acceptable response rate, a rigorous drafting and re-drafting process had been undertaken. I produced an outline questionnaire which became subject to criticism and debate by my two supervisors and myself. During several intensive meetings, wording was analysed, challenged, and re-designed as considered necessary. In all, four drafts of the questionnaire were produced until the final presentation was agreed upon. The result was a questionnaire which was deemed unambiguous and which had the potential to extract a maximum amount of information.

Validity

By enlisting the help of my supervisors in the drafting process I was able to not only overcome the problem of piloting the questionnaire but also to address the issue of validity. Validity is regarded as a question of whether one investigates what one is actually claiming to investigate (Sarantakos, 1998). When assessing a survey instrument Litwin (1995) explains that there are several forms of validity that may be considered; of these, the form most applicable to the orthopaedic surgeons questionnaire was content validity. Here, a review of the survey instrument is undertaken by individuals with expertise in the relevant aspect of the study; essentially the individuals assess the instrument in order to ensure that it contains everything it should, and does not contain anything it should not. At this stage my supervisors were Professor Elizabeth Ettorre and Professor Geoff Payne, both vastly experienced sociologists (on his retirement Professor Payne was replaced in his supervisory role by Professor Alan Petersen). After the rigorous drafting/redrafting process I have described, the finalised questionnaire met the expectations of both my supervisors and therefore can be said to have met the requirements of content validity.

Arskey and Knight (1999) list factors which enhance validity, two of which relate

directly to content. They are, firstly, schedules that contain questions drawn from the literature and from pilot work with respondents, and secondly, a set of questions that fully covers the issues raised by the research question, that is, key aspects are not ignored. I have explained that it was not possible to pilot the orthopaedics questionnaire but the questions it comprised were somewhat informed by Larkin's (1983) account of the allied health professions and, in particular, the historical guarding of professional boundaries by medicine. Of much greater influence, however, was my a priori experience as a podiatric surgeon. I have previously mentioned that I have experienced various forms of interaction with orthopaedic surgeons. When this is added to the fact that I am able to boast a vast experience in both private and NHS health-care, it is reasonable to assume that the questions posed in the questionnaire were pertinent and covered the relevant issues.

A further factor enhancing validity which was identified by Arskey and Knight (1999:52) was:

> A sample that is fit for the purpose of the research .....If the aim is to make claims about a group, or to give a rounded account of an event, sampling needs to ensure that all points of view are appreciated. Big samples, preferably selected at random, are needed if you want to claim that your findings are very likely to hold good for the population.

As noted earlier in discussing reliability, sampling was not an issue in researching by questionnaire in this study. A total population of orthopaedic surgeons was targeted and, as a result, all of the benefits arising from using a large sample described by Arskey and Knight can be claimed. Therefore, it may confidently be asserted that the questionnaire ensured that all points of view *were* appreciated and that the resultant findings *would* hold good for the entire population. This argument also applies to the questionnaire sent to podiatric surgeons where another total population was targeted and which will be described later.

Ethics

Traditionally ethical concerns revolve around:

(a) informed consent i.e. gaining agreement from a subject for his participation in the research process after providing a truthful and accurate account of what the research involves;

(b) the right to privacy i.e. protecting the identity of the subject;

(c) protection from harm (this could be physical, emotional or any other kind);

(d) accuracy i.e. there should be no fabrications, omissions, or contrivances

(Denzin and Lincoln, 2000).

According to Bulmer (1980) two elements are implied in being 'informed' and two that constitute 'consent'. They are:-

'Informed' –

1. that all pertinent aspects of what is to occur and might occur are disclosed to the subject;

2. that the subject should be able to comprehend this information.

'Consent' –

1. that the subject is competent to make a rational and mature judgement;

2 that the agreement to participate should be voluntary, free from coercion and undue influence.

All recipients of the orthopaedics questionnaire received a letter of introduction which detailed the purposes of the research and explained the importance to the project of the views of orthopaedic surgeons. They were not asked to sign a consent form but, by completing and returning the questionnaire on the basis of the information supplied, and without any coercion, it is evident that the requirements of informed consent were fulfilled.

Within the letter of introduction that accompanied the questionnaires, a guarantee of both anonymity and confidentiality was given. Anonymity means that data collected by the researcher should not be attributable to an informant by name or by any other means of identification; confidentiality means that information collected will be used for the purposes of the study and not made available for any other purpose (Sarantakos, 1998). Confidentiality fulfils not only an ethical principle but also a pragmatic function, that is, it facilitates greater accuracy and completeness with regard to the data collected (Hakim, 1979). In other words, when confidentiality is assured, respondents are liable to be more candid and less likely to adopt the 'halo effect' – the feeling that they need to create a good impression (Homan, 1991).

With regard to the return of the questionnaires, it was necessary to ascertain who had returned their questionnaires in order to avoid involving them in a repeat mailing. This was achieved by including an index number on the return envelope; on receipt the index number was registered as a return and the envelope marked with the index number destroyed, thus ensuring no further connection between the removed questionnaire and the index system. In practice, generally this procedure worked well though a small number of respondents obliterated the index number and, as a result, would have received a second mailing.

Maintenance of anonymity and confidentiality in the current research project ought also to ensure that no harm comes to any respondents. On a broader basis, no individuals are identified by name in any part of this dissertation; some individuals are referred to by way of their official position (though without names) and this was necessary in order to make sense of their involvement in my data gathering process.

With regard to accuracy, all data used within this report are derived from either completed questionnaires or from personal interviews which were tape-recorded. All

questionnaires remain available for inspection by others, as do the transcripts of the interviews and the tapes themselves; a slight exception to this is the small number of subjects who did not agree to tape-recordings of the interviews. In this case contemporaneous notes of the ensuing conversations were made and these remain available for any check on accuracy.

Questionnaire returns

One thousand, five hundred and fifty three questionnaires were sent to Fellows of the BOA resident in the United Kingdom. Seven hundred and six were returned representing a 45 per cent response. This response rate was acceptable as a 30 per cent return has been described as 'fairly satisfactory' and a 50 per cent return as 'good' (Gillham, 2000). Of the 706 questionnaires returned, 625 were fully completed. Of the other 81, 47 were returned uncompleted because the recipients had retired, 27 recipients considered it inappropriate to answer because they did not work with feet, 2 were returned as they had not reached the intended recipient because of a change of address, 4 recipients were unwilling to complete and 1 intended recipient was deceased. Despite the generally co-operative nature of the responses, some overt opposition to the questionnaires was encountered. Some were blatantly hostile –

> Do you think we have time for this sort of rubbish questionnaire? And if you have obtained our names and addresses (sic) you have the right to impose upon us for this? If you want to do a PhD do some real research, not postal surveys (scrawled across an uncompleted questionnaire).

Others were obstructive. Six letters were received (without completed questionnaires) complaining in various ways, about the questionnaires they had received. Two letters were quite lengthy and attempted to take me to task about the presentation and validity of the questions involved in the questionnaire; one of these concluded that the correspondent

was sending a copy of the letter to my Head of Department 'so that he is aware of the work coming from his department'. Of the other letters, one was from the latest President of the BOA. He noted surprise at receiving a questionnaire after provision of a mailing list had been refused. He also reported 'considerable disquiet in the UK about podiatric surgery proximal to the forefoot, and some of the practices that have been accepted by Trusts'. If this letter was intended as a form of rebuke I considered it unwarranted; the refusal of the BOA hierarchy to grant me approval for distribution of the questionnaire was within their rights but the reasons they had given for refusal I believed to be spurious. Furthermore I had obtained the mailing list from a public document and therefore did not consider that I had acted in an underhanded way. The President's comments on attitudes towards podiatric surgery served simply to confirm that the issue was a contentious one. In fact, I believed this also to be confirmed by the high response rate of the questionnaires. Having originally held a low expectation with regard to response rates, the high return I received I took to be evidence that podiatric surgery was a subject about which orthopaedic surgeons felt strongly, whether they were supportive or not. Furthermore, the strong responses prompted by the questionnaires which I have outlined above also indicate that the subject of podiatric surgery was one that invoked fairly passionate feelings among orthopaedic surgeons.

Questionnaire data analysis

As I explained earlier in this chapter, the majority of the questions involved in the questionnaire were closed and they produced data which was easily entered into a SPSS programme with variables automatically assigned code numbers by the programme.

The results of the open question which asked about the advantages or disadvantages of regulation of podiatric surgery by orthopaedics had to be categorised to allow coding. In order to do this, reference was made to the method described by Arskey and Knight (1999) and which is more fully discussed in analysing the personal interviews (see later). In categorising the answers to this open question, all responses were examined when questionnaire collection was complete. This ensured continuity in categorisation; if categorisation is begun before collection is complete, there is a danger of forgetting the basis on which a factor is allocated to a category when it comes to dealing with the later questionnaires (Arskey and Knight, 1999).

As examination of the questionnaires began, themes and concepts were identified; these themes or concepts were labelled as categories and these categories were then applied to each subsequent questionnaire as they were examined. When all questionnaires had been examined and a preliminary categorisation had been made, each questionnaire was re-examined and the 'fit' of each response into its category was reconsidered. The intention here was not only to ensure that categorisation for each response was appropriate, but also to review the categories and determine if some were sufficiently similar to be merged, perhaps providing that category with a new and more apt label.

With this review of the categories complete, and changes made as appropriate, a colleague was enlisted to examine a sample of questionnaires. Having been provided with an explanation of the basis of category application, she was asked to consider the sample for category 'fit'. This provided a measure of inter-observer reliability and avoided the possibility that my judgement could be 'eccentric' (Arskey and Knight, 1999). The categories which resulted from this analysis fell into three thematic areas:-

1. advantages of regulation:

uniformity;
control;
integration;
control of scope of practice;
better patient care;
improved status of podiatrists.

2. disadvantages of regulation:

orthopaedics should not take on the responsibility and risks involved;
increased confusion regarding the role of podiatric surgeons.

3. further comments:

uncomplimentary remarks;
podiatrists lack the capabilities of orthopaedic surgeons;
concern about scope of podiatry practice;
orthopaedics are only likely to encounter podiatric failures, not successes;
ignorance regarding podiatric regulation;
denigration of the questionnaire;
objection to use of title (consultant/surgeon);
non-medically qualified people should not perform surgery.

With coding of the open question complete, the results were entered into the SPSS Computer Programme. At this stage I felt both surprised and pleased with the high level of response I had received from the orthopaedic surgeons. Notwithstanding the occasional hostile reply, in various forms, I was satisfied that the questionnaires had fulfilled the overriding objective; I had gathered a large amount of relevant data regarding attitudes towards podiatric surgery. Equally important was the willingness to be interviewed shown by a significant number of surgeons. With the data derived from the questionnaires now entered on computer, my thoughts turned to adopting an appropriate interview strategy.

5.4 Interview methodology

The merits of interviews were discussed earlier in this chapter. With questionnaire results providing a large quantity of information, I now looked to interviews to add depth to the

data. Personal interviews were an appropriate choice because they are a means by which one may

> attempt to understand the complex behaviour of members of society without imposing any a priori categorization that may limit the field of enquiry
>
> (Fontana and Frey, 2000:653)

Interview design

Each questionnaire invited the respondent to take part in a personal interview to further explore some of the issues raised in the questionnaire. From the 706 respondents who returned questionnaires, 143 indicated their willingness to be interviewed (that is, 20 per cent of those who responded). Of the 143, 15 agreed to face-to-face interviews only, 8 provided insufficient or ineligible contact details, 2 had retired more than 5 years previously and were not considered to be sufficiently current in their views, and 3 were local orthopaedic surgeons whom I considered it best to avoid; these local surgeons are known to me but it cannot be said that we enjoy a working relationship. I felt that personalities and local health-care politics might impose on any personal interviews I could undertake with these consultants and, consequently, the validity of those interview results might be questionable. I also felt, in the long term, my own professional position could be disadvantaged.

By this stage, I realised that, because of geography, it was not practical to conduct face-to-face interviews. Therefore, only those who had indicated a willingness to undergo telephone interviewing were considered. Of these, 85 had personal experience of podiatric surgery and 30 did not. This represented roughly a 3:1 ratio. I felt that undertaking 115 telephone interviews was not manageable mainly because of time constraints, so I decided to select a sample.

There are varying opinions on how large the sample should be (Spradley, 1979;

McCracken, 1988) but, whatever the sample size, it is necessary to gather information from all relevant perspectives (Arskey and Knight, 1999; Warren, 2001). I attempted to do this by basing my sample on the 3:1 ratio mentioned above. I considered this appropriate because those respondents who had some direct experience of podiatric surgery were likely to argue from an informed position and, as a result, could probably provide detailed arguments. At the same time, the views of those with no direct experience were no less important in attempting to assess the prevailing attitude of the orthopaedic body as a whole towards podiatric surgery.

I considered 50 interviews to be achievable and this represented 43 per cent of those willing to be interviewed. I felt that this number ought to be large enough to achieve the main aim of the interviews which was to fully explore the main themes arising from the completed questionnaires. The pool of 115 was divided into those with, and those without experience of podiatric surgery and the first 50 subjects for the sample were simply those appearing at the top of the lists, allowing for the 3:1 ratio. However, when the interviewing process commenced it sometimes proved difficult to make contact with the prospective interviewees; despite having indicated their willingness to be interviewed some were consistently 'busy' in answer to repeated telephone calls whilst others openly withdrew their original offer. When one individual was withdrawn from the sample it was necessary to replace them with the next in line from the larger pool of 115; this was done while trying to maintain the approximate 3:1 ratio.

Telephone interviewing is a popular and widespread method of data collection (Sarantakos, 1998). It has been criticised for its limitations in producing the 'natural' conversation which is partly dependent on the 'visual clues' of face-to-face conversation (Arskey and Knight, 1999; Shuy, 2001), and it is claimed that complex issues are better dealt with in a face-to-face situation (Shuy, 2001). However, telephone interviewing

does produce quick results, allows the study of relatively large samples, and is relatively economical (Sarantakos, 1998). It also has the benefit of reducing any interviewer effect (Shuy, 2001).

A voice-activated Dictaphone was purchased to facilitate recording a telephone conversation. Tape recordings are a means of enhancing the reliability of interviews as they (and transcripts) are a public record available to the scientific community in a way that field notes are not (Silverman, 1995). For reasons of public access and accuracy, Perakyla (1997) also advocates tapes as a method of aiding reliability but cautions that attention should also be paid to the way that conversation links with other forms of social interaction. Silverman (1995) also notes that there are charges that data based solely on tape recording are incomplete as such things as facial expressions are omitted. However, in reaffirming the value of tape-recording interviews he cites Saks (1992) who asserts that 'completeness' is an illusion, that is, there cannot be totally 'complete' data.

All informants were reminded at the beginning of the telephone conversation that they had returned a questionnaire and had agreed to participate in an interview; they were also reminded of the purposes of the research. All agreed to continue with the interview without coercion; informed consent can, therefore, be regarded as having been obtained. As the taping of the telephone interviews demands agreement from the informant (Holloway and Wheeler, 1996), permission was sought at the outset of each conversation. A small number of informants refused permission and in these cases contemporaneous notes were taken instead.

Caution has been urged with regard to the length of time spent on a telephone interview, and restricting the length usually makes it more focused (Gillham, 2000). The longest interview with the orthopaedic surgeons was 15 minutes, with an average

duration of 8 minutes. All interviews were undertaken over a three week period. The style of the interviews was semi-structured and followed the form suggested by Rubin and Rubin (1995) by using main questions to begin and guide the conversation, probes to clarify answers, and follow-up questions to pursue the implications of answers to the main questions. Three main questions were employed and were formulated as a result of data gathered from the earlier questionnaires. They were:

firstly, "Do you have any specific objections to podiatric surgery?" (Less commonly when the informant's questionnaire indicated an alternative stance, the first question would ask why the informant was in favour of podiatric surgery);

secondly, "Given that podiatric surgery is now present in some NHS Trusts, if this trend continues what would be the advantages or disadvantages to orthopaedics?";

thirdly, "Can you foresee a way in which orthopaedics and podiatrists could establish a satisfactory working relationship?"

These questions were phrased in a value-neutral way in order to avoid the concern about the veracity of in-depth interviews noted by Freeman (1983) who found that sometimes informants will tell the interviewer not what they believe, but what they believe the interviewer wishes to hear. Even so, despite attempts to encourage sincerity amongst informants, it should be noted that it is impossible to know if they were totally frank in their responses. As I explained earlier in this chapter, I was honest about my status whenever I was asked; some informants enquired about this but most did not. When I did reveal my status I was not conscious of any change of attitude which might suggest responses were altered in some way as a consequence. If one examines the results of the interviews there are few which can be considered to be 'diplomatic'; most results are polarised – either anti or pro- podiatric surgery. Although one may argue that, if Freeman's concern was applicable here, the informants may be more likely to adopt a pro-podiatry stance, I was given no reason to suppose this occurred.

The questions were also designed to be sufficiently open to encourage informants to express themselves as fully as they wished, at any length, and on any issue within the orthopaedic-podiatric surgery relationship. Beyond the main questions, no pattern to the interview was planned which allowed the conversation to follow any turns or digressions that arose from the informant's interests or concerns. Such flexibility is advocated as it is often highly productive (Johnson, 2001).

For Arskey and Knight (1999) the validity of interviews is enhanced by:

- Interview techniques that build rapport, trust and openness and which give informants scope to express the way they see things;
- Not asking questions that are irrelevant to the research topic – a waste of scarce interview time;
- Prompts that encourage informants to illustrate, expand and clarify their initial responses, talking in detail and about specifics.

The interviews conducted attempted to encompass these points whilst maintaining a certain level of consistency. Openness was provided by clear explanation of the purposes of the study and relevant background details. When asked about my status, my qualification as a podiatric surgeon was admitted without hesitation. On no occasion did I sense a reduction in co-operation following this disclosure and the interviews continued in an apparent frank and open manner, suggesting an element of trust and perhaps rapport. Consistency was maintained by adhering to the three opening questions. However, the format remained sufficiently flexible to allow the informant to follow whatever line of description or argument he or she felt willing to explore. In this way informants were able to fully express themselves.

Beyond the three opening questions, the only questions asked were, firstly, those involved in opening pleasantries which were an important part in establishing a rapport, and

secondly, prompts which sought to focus the conversation where necessary or, more often, which sought to further illuminate important points raised by the informant.

In order to build rapport and increase disclosure I attempted to employ 'complimentary reciprocity'. This is a form of information exchange which usually becomes possible after the completion of several interviews; some of the information gained from earlier interviews is fed back to later informants. Not only does this build rapport, it also acts as a verification process. As a result the later interviews of the project may be focused on specific probes and verification of what has been learned in earlier interviews (Johnson, 2001). Complimentary reciprocity and verification is illustrated mid-way through interview 41:

R.G.: One of the recurring themes, actually, in these interviews I've conducted so far, is a fear that the training opportunity for young orthopaedic surgeons would be diminished if all the foot surgery gets passed off.

Informant: Oh absolutely. It's difficult really, because, I mean, I think there's a border-line and that just has to be defined really. I mean, there's certainly a lot of things that surgeons wouldn't want to do or wouldn't be interested in doing in podiatry, but there's got to be a stop, when you actually open up the flesh as it were and start to alter the position of bones and ligaments. And I think that needs surgical training and I think the more we get into it, the more we understand the biomechanics of the foot, the more complicated it actually is.

R.G.: Right, right.

Informant: And certainly, you know, it's an expanding field that needs to be addressed by the proper training of our youngsters.

By the application of these principles, not only was a reported concern about training opportunities for orthopaedics verified but the informant's additional comments confirmed earlier data which indicated a widespread belief that only 'trained surgeons', that is, those with a medical qualification, should perform surgery.

Interview data analysis

With fifty telephone interviews completed, the results were transcribed. Reliability of transcripts is enhanced by the researcher carefully undertaking the transcription themselves and not handing the task to an audio typist (Silverman, 1995). Analysis of the transcripts then followed the pattern suggested by Arskey and Knight (1999), supported by Ryan and Bernard (2000), and which conformed to the approach adopted in analysing the open question element of the questionnaires. Arskey and Knight (1999) commend elements of grounded theory (Glaser and Strauss, 1967; Strauss and Corbin, 1990) in analysing qualitative data. First a sample of transcripts is examined with the intention of searching for emerging themes. As a result the transcribed material is divided into categories and these categories are then checked for adequacy against new data as they are collected. To determine adequacy the following questions are asked:

(a) do the categories formed cover all the data that are relevant to the research?
(b) are new categories needed?
(c) should existing categories be divided into sub-categories?
(d) are there too many categories i.e. can categories be amalgamated because the differences between them are so slight?
(e) does the emerging sense of what should be included in a category require a review of earlier transcripts?

(Arskey and Knight, 1999)

Analysis of the orthopaedic transcripts differed from that advocated in grounded theory in that categories identified initially were not checked against new incoming data but, instead, all fifty transcripts were analysed in succession with emerging themes noted on the transcripts themselves and then placed in a central register. As all the transcripts were examined in prompt succession, a consistency of analysis was ensured and the ability to make connections between things said in different interviews was enhanced. As a result,

the analysis of later transcripts benefited from a clear appreciation of themes emerging from the earlier ones.

With all transcripts analysed, the categories entered into the central register were examined against the list of questions posed by Arskey and Knight (1999) (see earlier). When similarities between categories were noted, the basis for the allocation of those categories was reviewed. If, on review, there was significant differences between categories those categories were retained, but if not, the categories were merged, perhaps with alteration to the title. For example, two initial categories were 'Objection to title' and 'Use of term *Surgeon*' which referred to displeasure at podiatrists using the terms *Consultant* and *Surgeon* respectively. These categories were sufficiently similar, with an allied underlying sentiment, to be merged as one category and given the label 'Objection to title'.

A further example of changes made after reviewing the initial categories related to the question of possible advantages or disadvantages arising from an increased provision of podiatric surgery within the NHS. The original category of 'Benefits' was found not to be sufficiently discriminating so additional categories of 'Benefits for patients', 'Benefits for orthopaedics', 'Benefits of communication' and 'Benefits generally' were created.

With the central register of categories altered appropriately the transcripts were revisited, the new categories examined for 'fit', and a change of category noted on the transcripts as appropriate.

Adequacy of data analysis

Inter-rater agreement or inter-observer reliability is a concept which establishes the accuracy of the categorisation process and ensures that the researcher's judgement in

devising categories has not been 'eccentric' (Arskey and Knight, 1999), thereby enhancing reliability (Silverman, 1995).

In order to achieve inter-rater agreement, my two supervisors were each provided with a random selection from the transcripts and asked to annotate the script with themes they might identify. The scripts with identified categories were then compared with the identical scripts which I had previously categorised. The disadvantage to the supervisors was that they did not enjoy the benefit of 'immersion' in previous scripts to which I had been privileged and therefore were not privy to collectively emergent themes from the transcripts. They were also asked to work without a list of labelled categories to which they could refer. Inevitably, then, the labels they eventually attached to categories were not identical to those I had used. However, in both cases, there were marked similarities between many of the categories identified by the supervisors and those which I had identified as shown in the comparisons below:

Supervisor 1	**R.G.**
Opinion of podiatry	Podiatry lacking capability
Clinical governance	Clinical governance
Working independently	Podiatry independence
In association with	Co-existence
Subordination	Superiority of orthopaedics
	Control

Supervisor 2	**R.G.**
Professional competence	Podiatry lacking capability Poor work by podiatrists
Training	Disadvantage for orthopaedic training

Opportunities for orthopaedic training
Ignorance regarding podiatric training

Right to practise

Not medically qualified

Additionally there were some more tenuous links between categories. For instance, Supervisor 1 identified orthopaedics' 'diagnostic right' which I had interpreted as 'the superiority of orthopaedics'. There were also some themes identified by the supervisors to which I had attached no labels at all because I did not consider them relevant to the research. This was not surprising given the supervisors' limited terms of reference, and that it is normal to get a lot of 'background noise' in transcripts which is irrelevant to the research aims and which cannot be used (Arskey and Knight, 1999). However, there were no obvious disagreements between relevant categories identified by myself and my supervisors and it was therefore justified to claim that categorisation had not been 'eccentric'.

I had now completed my data collection with regard to orthopaedic surgeons. As I have previously indicated I found this had been an arduous process. I felt I had learned much about inter-professional relationships, professional closure and 'gate-keeping' to which I referred earlier in this chapter. However, both the questionnaire survey and the series of personal interviews had been highly successful. I had amassed a considerable amount of data from the questionnaires and this data had now been enriched by the results of the personal interviews. I was now to embark on my final stage of data collection which I hoped would prove to be much less problematic as it involved a population to which I belonged – podiatric surgeons in the UK.

5.5 Questionnaire design – podiatric surgeons

The final area of data collection concerned gathering information on the views of podiatric surgeons towards orthopaedic surgeons. As I explained at the beginning of this chapter, my experience as a podiatric surgeon had provided an in-depth 'feel' for the prevailing attitudes. However, it was important to quantify, in some manner, the extent of alleged conflict between the two disciplines and to explore any potential willingness to promote co-operation. There could also be areas of the inter-disciplinary relationship of which I was ignorant.

All surgical Fellows of the Society of Chiropodists and Podiatrists were sent a questionnaire (see Appendix 2). The questionnaire design was based on that adopted for the orthopaedic surgeons. In appearance, format, and where possible, content, the podiatric questionnaire reflected the orthopaedic design but inevitably there were differences. The questions asked about: personal details (age, gender, etc); levels of surgical activity (which could have a bearing on the amount of interaction with orthopaedics); the amount and nature of interaction with orthopaedics and whether that interaction had been satisfactory or unsatisfactory; strategies that may have been employed in the face of unsatisfactory interaction; attitudes towards forming a more formal working relationship with orthopaedics

A further question asked whether the respondent would consider working under the direction of orthopaedics in a dedicated foot-care team and also asked for an explanation of their answer. This question arose as a direct result of data gathered from orthopaedics which suggested orthopaedic surgeons could be more willing to establish a working relationship with podiatric surgeons if they could maintain some level of control.

The podiatric surgery questionnaire underwent the same rigorous drafting/re-drafting process as that for orthopaedic surgeons with wording examined for ambiguity,

consideration given to the sequencing of questions, the avoidance of negatively worded questions, and the use of questions which involved as few words as possible. The open/closed mix was more evenly balanced than in the orthopaedic surgeons questionnaire with four questions (5, 6, 7, 8) involving six sub-sections of open questions. Rating scales were employed in three questions, two of these involving five reply categories and one involving four (see Appendix 2).

As with the orthopaedic surgeons' questionnaire, it was not practical to either trial or pilot the podiatric surgery questionnaire. Here the total population was 148 which meant not even a small sample could be expended on piloting. The target population of podiatric surgeons was highly specific and the experiences to be investigated were also context specific which meant that no alternative group existed that would be suitable for trialling. It was decided that the drafting/re-drafting process would provide the benefits to be gained from piloting in the same way as this had applied to the orthopaedic surgeons' questionnaire. In due course this appeared successful as no obvious areas of ambiguity were detected in the returned and completed questionnaires.

The arguments put forward to support the reliability and validity of the orthopaedic surgeons questionnaire also apply to the podiatric surgeons questionnaire. Two points, in particular, are worthy of emphasis: firstly, earlier in the chapter I noted Arskey and Knight's (1999) assertion that validity was enhanced by schedules whose content was pertinent and fully covered the issues raised by the research question. The contents of the podiatric surgery questionnaire can be regarded as pertinent as the questions were informed by the results of the orthopaedic surgeons' questionnaire as well as my own experiences as a podiatric surgeon. Secondly, as with the one sent to orthopaedic surgeons, this second questionnaire targeted an entire population and, as will be explained later, an

even higher response rate was achieved with the podiatric surgeons. By researching an entire population the requirements for reliability noted by Litwin (1995) and validity described by Arskey and Knight (1999) (both explained earlier) are met; it is therefore appropriate to draw inferences about the population from the collected data.

The podiatric surgeons' questionnaires were accompanied by a letter of introduction which explained the purposes of the research and, through this, the issue of informed consent was addressed. Other ethical issues such as confidentiality and anonymity were covered in the same way as with the orthopaedic surgeons' questionnaires.

Access

I held a membership list of podiatric surgeons through my professional affiliation. However, as a matter of courtesy, contact was made with the Society of Chiropodists and Podiatrists and permission sought to send a questionnaire to podiatric surgeons. A letter of explanation which included a brief account of the research project to date and a sample questionnaire were sent to the Society. Following a brief delay while the request was considered by the Council of the Society, permission for distribution of the questionnaire was granted and a membership list was provided in the form of adhesive address labels.

Questionnaire return and analysis

The questionnaires were dispatched and second and third mailings were sent to those from whom no reply had been received after a certain time had elapsed. One hundred and forty eight questionnaires were sent and 111 completed questionnaires were returned, representing a return of 75 per cent. I consider this high response rate to be due to two factors: firstly, the relatively small size of the surgical faculty of the Society of Chiropodists and Podiatrists means there is something of a fraternity attitude amongst its

Fellows. As a result individuals are inclined to assist their peers when possible. Secondly, the podiatry-orthopaedics relationship is an emotive issue with most podiatric surgeons; an opportunity to comment on this relationship is likely to be readily accepted.

Of the returned questionnaires, 100 produced data. Of the remaining 11 which were uncompleted, 8 recipients were no longer practising surgery, one recipient had retired, one felt unable to comply though he did not offer an explanation, and one did not complete the questionnaire because he found the format too restrictive. The data gathered from the questionnaires were entered into a SPSS programme. As with the data from the orthopaedic surgeons' questionnaires, those data derived from closed questions were automatically allocated numerical values by the programme. With the data derived from the open questions the same format was followed as with the orthopaedic surgeons' questionnaires: questions were examined, categories identified, and the questionnaires re-examined to ensure adequacy of category 'fit'. Once again, a colleague was consulted for a second opinion where areas of difficulty were encountered. The resultant categories were entered as data into the SPSS programme. Table 1 summarises the questionnaires sent and received back from both the orthopaedic surgeons and the podiatric surgeons.

	Orthopaedic Surgeons	Podiatric Surgeons
Questionnaires sent	1553	148
Questionnaires returned	706	111
Response rate (%)	45	75
Fully completed	625 (40% of questionnaires sent)	100 (68% of questionnaires sent)

Table 1: Questionnaires

5.6 Summary

The process of data collection in the current study was time-consuming, somewhat frustrating, but ultimately successful. All elements – design/construction of the research instruments, questionnaire dispatch, and data analysis – involved lengthy procedures. Gaining access to the orthopaedic surgeons mailing list proved to be the most daunting, and ultimately, the most time-consuming aspect of the activity overall.

The choice of the data collection methods was justified. Both questionnaires, targeting entire populations, produced good response rates and elicited much factual information from which it is appropriate to draw inferences about both populations. The semi-structured interviews with orthopaedic surgeons served their purpose which was to add richness and depth to the information gained from the questionnaires. As two complete populations were researched, and the methods of research achieved good response rates, it is my contention that the validity of the findings can be viewed with confidence. As such, I believe that another researcher following the same approach would produce similar results.

The data collected are described in more detail in the following chapter. They should be considered within an appropriate context, that is, they need to be viewed against the historical backdrop described in earlier chapters. This involves the rise to prominence of the medical profession, its dominance of health-care in general, and, in particular, the subordination of the paramedical occupations. Only with an appreciation of how powerful the medical profession has become over the last one hundred and fifty years can one understand the full implications of the challenge to one of the most prominent medical specialities – orthopaedic surgery – from the 'new' discipline of podiatric surgery.

Chapter 6
How do Orthopaedic and Podiatric Surgeons View Each Other?

In this chapter I present the results of the orthopaedic surgeons' and podiatric surgeons' questionnaires. Most of the data gathered from these questionnaires is quantitative in nature and so I describe them here with minimal interpretation, that is, the results are offered in numerical form together with an explanation of their meaning within the context of the research project. However, greater analysis is left to the following chapter. By adopting this format I hope that an examination of this chapter will prove interesting and that the reader will arrive at the end of the chapter with an appreciation of the prevailing themes arising from the results; these themes can then be considered in greater depth in Chapter 7. By the same reasoning I do not refer to the results of the interviews with orthopaedic surgeons within the current chapter; this would have amounted to little more than a count of recurring topics and, as qualitative results, I believe they are best dealt with, and in greater depth, separately in Chapter 7. All the quantitative results can be found in 'Appendices'. SPSS generated tables include a 'valid percentage' which takes into account the number of missing entries, and a 'cumulative percentage' which shows, for each value in the distribution, the percentage of the total number of cases up to and including that value.

Prior to undertaking statistical analysis I consulted some acknowledged sources on the subject and then, having decided upon the appropriate statistical tests to employ, I sought confirmation from a statistics expert within my university department that my choice was suitable for the type of data I had collected. With the benefit of that confirmation my first task was to 'clean' the data. Argyrous (2005) describes 'data cleaning' as a process of checking that data do not contain invalid or nonsensical values

and advocates generating frequency tables and crosstabulations to check for this. As I explain below, these tables were to form the basis of my analysis and so they would also be useful for the purposes of data cleaning; however through my consultation of texts on statistical analysis I had also been alerted to the potential problems of 'missing values'. Miller et al (2002) explain the various reasons why missing values may occur; these values may be truly 'missing' or they may represent a situation where an answer may have been non-applicable to a particular respondent. On entering the data from the questionnaires I had not entered missing values as I was aware that SPSS had a facility for entering a 'system' missing value, that is, the system would recognise and note a non-entry. However, most sources agree that one should not rely on this and a safer way to avoid errors is to input a 'user' missing value, in other words, a number which clearly signifies a missing value should be input together with all other entries (Fielding and Gilbert, 2000; Miller et al, 2002; Argyrous, 2005). On a manual examination of the inputted data the utility of this argument was clear. On several occasions I found entries which should not have existed but they occurred because respondents had not correctly followed the instructions of 'skip' or 'filter' questions (Argyrous, 2005). As a result there were entries to questions that were actually non-applicable. Appropriate corrections were made and 'user' missing values were entered.

As I mentioned earlier, I decided to use frequency tables and crosstabulations to analyse the refined data.

6.1 Frequencies

> A simple frequency table reports, for each value of a variable, the number of cases that have that value

In addition,

> Relative frequencies express the number of cases within each value

of a variable as a percentage or proportion of the total number of cases.

Also,

A cumulative relative frequency table shows, for each value in a distribution, the percentage or proportion of the total number of cases up to and including that value.

(Argyrous, 2005: 55, 57, 60)

As I stated earlier, most of the data emanating from the questionnaires were quantitative. I expected, for instance, that the data would confirm that the two disciplines were male dominated. Gender could have a bearing on orthopaedic attempts to subordinate podiatric surgeons (Willis, 1994), which I discuss in the next chapter. I also wanted to know such things as the number of orthopaedic surgeons who regard podiatric surgeons as suitably trained and qualified which might affect willingness amongst the former to collaborate with the latter, and how many podiatric surgeons may be open to entering into a more formal working relationship with orthopaedic surgeons. Frequency tables were, therefore, an appropriate tool of analysis for these data.

6.1.1 Frequency tables – orthopaedic surgeons

1. Gender

gender

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	male	637	97.8	98.5	98.5
	Female	10	1.5	1.5	100.0
	Total	647	99.4	100.0	
Missing	System	4	.6		
Total		651	100.0		

Table 2: Gender of orthopaedic surgeons

As the previous table demonstrates, males overwhelmingly dominate orthopaedic surgery in the UK with females forming less than two per cent of the profession. When we later consider the gendered composition of podiatric surgeons we will do so knowing that they are in competition with a heavily male-dominated rival.

2. Age

The mean age of orthopaedic surgeons is just over 50. The highest percentage of surgeons are found in the 40-49 age band (41.5 per cent) and is clearly seen in Figure 1 which follows (for further details see Appendices). No orthopaedic surgeons are to be found under 30 years of age. While a small percentage of surgeons are found in the over 70s age band (2.5 per cent) it is fairly likely they are no longer practising. A comparison of the age and gender of orthopaedic surgeons with podiatric surgeons is made in Chapter 7.

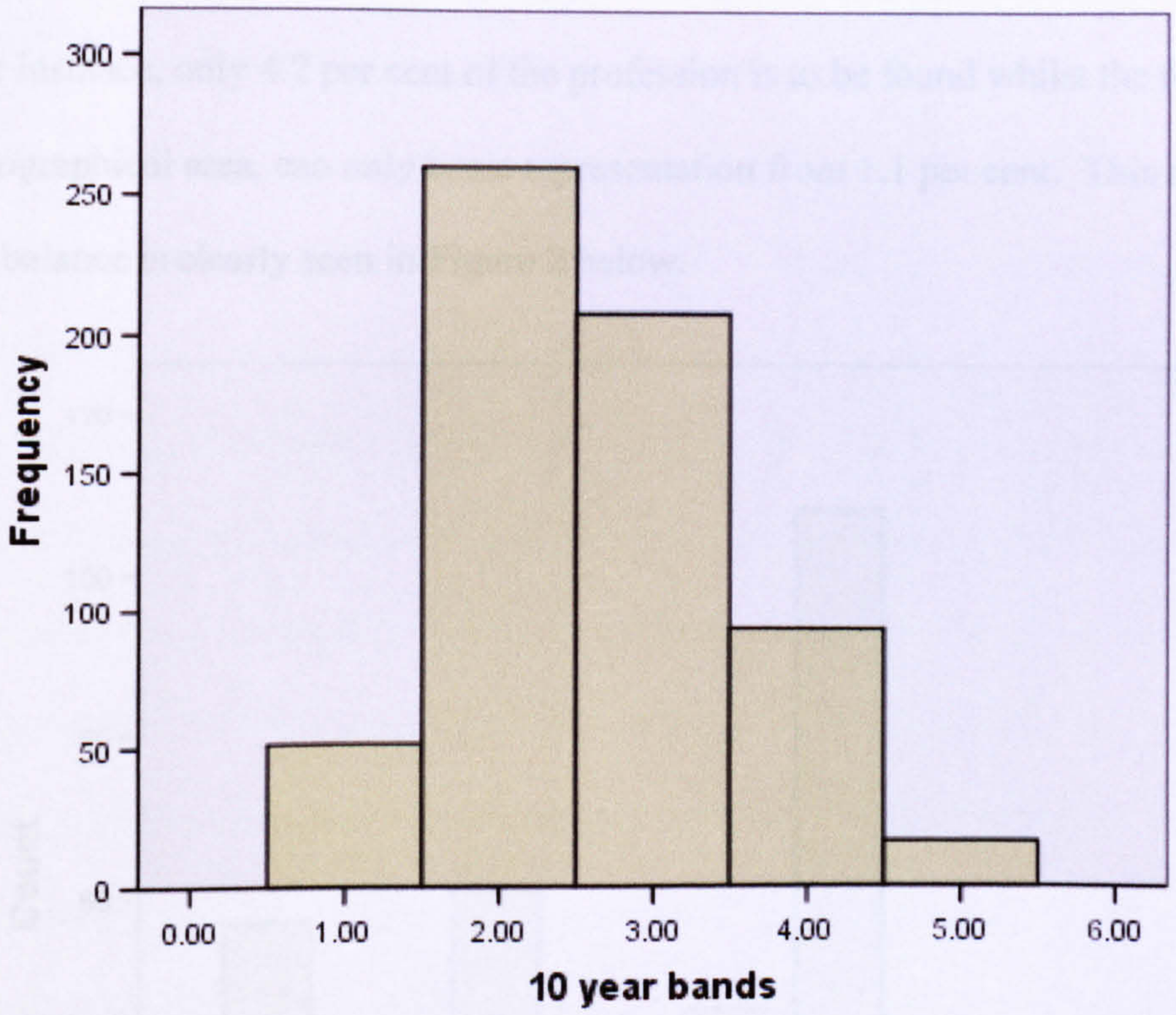

Fig. 1: Ages of orthopaedic surgeons

1.00 = 30-39 years
2.00 = 40-49 years
3.00 = 50-59 years
4.00 = 60-69 years
5.00 = 70+ years

3. Geography

The largest percentage of orthopaedic surgeons is to be found in the south-east (23.7 per cent). Some areas of the UK seem particularly underpopulated; in Wales and the Borders for instance, only 4.2 per cent of the profession is to be found whilst the north-east, a large geographical area, can only boast representation from 1.1 per cent. This apparent imbalance is clearly seen in Figure 2 below.

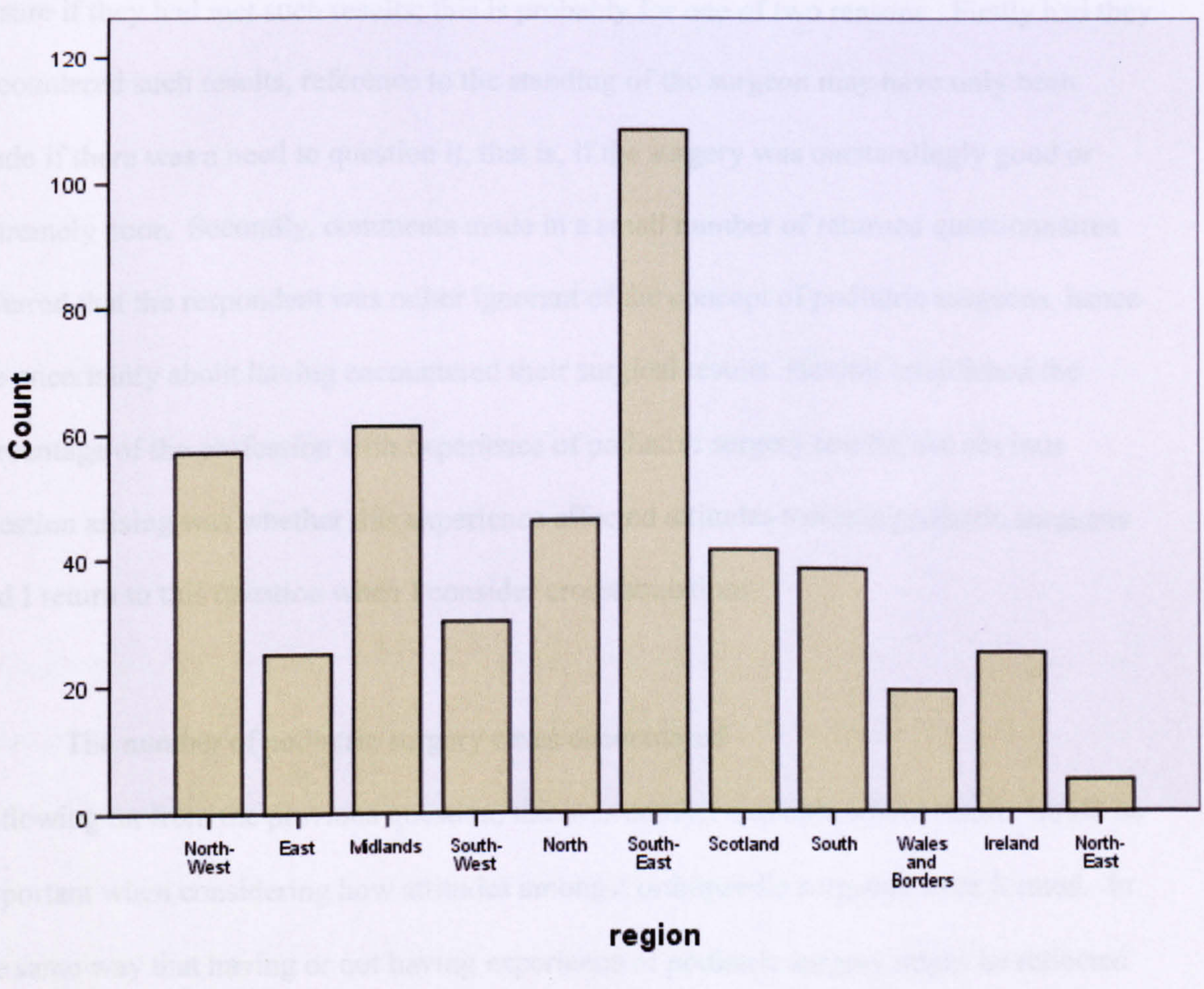

Fig. 2: Geographical regions in which orthopaedic surgeons practise

A comparison of the geographical breakdown of orthopaedic surgeons with podiatric surgeons is made in Chapter 7, the significance being that, in areas of numerical

superiority, orthopaedic surgeons could have a stronger base from which to help or hinder the progress of podiatric surgery.

4. Experience of encountering the results of podiatric surgery

The majority of the profession has experience of the results of podiatric surgery (just over 54 per cent) but a large number does not (nearly 40 per cent). Nearly 6 per cent were unsure if they had met such results; this is probably for one of two reasons. Firstly had they encountered such results, reference to the standing of the surgeon may have only been made if there was a need to question it, that is, if the surgery was outstandingly good or extremely poor. Secondly, comments made in a small number of returned questionnaires inferred that the respondent was rather ignorant of the concept of podiatric surgeons, hence the uncertainty about having encountered their surgical results. Having established the percentage of the profession with experience of podiatric surgery results, the obvious question arising was whether this experience affected attitudes towards podiatric surgeons and I return to this question when I consider crosstabulations.

5. The number of podiatric surgery cases encountered

Following on from the previous question, this was another example where results would be important when considering how attitudes amongst orthopaedic surgeons were formed. In the same way that having or not having experience of podiatric surgery might be reflected in attitudes towards the discipline, the number of cases encountered could have a bearing. The question arises, would attitudes be different when one had experience of only one case from when one had met over ten? Again I return to this under crosstabulations.

Number of cases encountered					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	14	2.2	4.0	4.0
	2-5	124	19.0	35.1	39.1
	6-9	54	8.3	15.3	54.4
	10+	161	24.7	45.6	100.0
	Total	353	54.2	100.0	
Missing	System	298	45.8		
Total		651	100.0		

Table 3: The number of podiatric surgery cases encountered by orthopaedic surgeons

The table above shows that, of those with experience of podiatric surgery, nearly half claimed to have encountered in excess of ten cases. One can only accept this at face-value though the possibility should be noted that an individual could inflate the number of cases encountered to bolster their claim that they speak from a position of authority.

6. Technical results

This question asked the respondent to evaluate the results of the podiatric surgery they had encountered from a technical point of view. Nearly half the respondents found the results technically unsatisfactory though nearly 40 per cent found them satisfactory. In Chapter 7 I discuss Abbott's (1988) caution about the veracity of one discipline evaluating the results of another's work but, briefly, he agues that there is a danger of the assessing discipline taking advantage of the opportunity to 'score points' against its rival.

7. Types of failure

Those finding the results technically unsatisfactory were asked to categorise the failures from pre-defined alternatives. Six categories were offered with a seventh (other failures) provided together with a request for elaboration. The following table summarises the results of this question:

Type of failure:	Percentage of respondents reporting failure *
Inappropriate choice of procedure	70
Persistent pain beyond normal post-operative duration	69
Non-correction of deformity	63
Infection	53
Transference of pressure from operative site onto other areas	49
Unacceptable reduction in joint range of motion	26
Joint instability	15
Technical incompetence	14
Postoperative haemorrhage	6
Non-union of bone	3
Systemic complications	3
Local anaesthetic failure	3
Reflex sympathetic dystrophy	3

Table 4: Types of technical failure in podiatric surgery encountered by orthopaedic surgeons

* Percentage rounded up to nearest full figure.

The category of 'technical incompetence' is a little vague and could theoretically encompass any of the other categories but respondents either used this phrase exactly or were sufficiently vague to be entered into this 'blanket' category. It is worth noting that the largest category involved podiatric surgeons undertaking an 'inappropriate choice of procedure'. This is a rather value-laden term and may not so much reflect a true technical failure as the fact that orthopaedic and podiatric surgeons follow different philosophies. As a result, what an orthopaedic surgeon views as an 'inappropriate procedure', a podiatric surgeon might consider to be justified. I return to this topic in the next chapter.

8. Patient satisfaction

Having asked the respondents to evaluate the results of podiatric surgery from a technical point of view, they were then asked to do so from the viewpoint of the patient, that is, assess the level of patient satisfaction. The two concepts can be mutually exclusive; it is possible, for example, for the patient to be pain-free and pleased with the surgery when, technically speaking, the result is of poor quality. The results are similar to those of the technical results question, nearly half reporting dissatisfaction amongst patients and almost 40 per cent reporting satisfaction. The effect of the technical results and the levels of patient satisfaction achieved on the formation of attitudes is considered under crosstabulations. Patient satisfaction is, of course, another form of surgical result and therefore, following Abbott (1988), answers to this question should be viewed with the same caution as responses to the question on technical results.

Having established the level of familiarity of orthopaedic surgeons with the results of podiatric surgery, the next set of questions sought to investigate attitudes. In response to a statement the respondent was asked to tick one of five options on a Likert scale, Strongly agree, Agree, Neither agree nor disagree, Disagree, Strongly disagree. Statements 9-13

relate to the increased provision of podiatric surgery in the NHS. The results form a fairly predictable pattern in that, overall, they demonstrate a lack of enthusiasm for such an increase.

9. Statement – An increase in the availability of podiatric surgery in the NHS would lead to a decrease in orthopaedic waiting lists.

Whilst the single largest category resulting from the responses to this statement involved those who ticked the Agree box (26.6 per cent), overall respondents disagreed with this statement; 46 per cent did not believe that orthopaedic waiting lists would decrease. Nearly 25 per cent were unsure. The figure of 46 per cent appears to reflect an attitude later to be found in personal interviews, that podiatric failures would increase demands on orthopaedic surgical lists with the greater need to perform surgical revisions; as such the results closely mirror those in response to statement 12 below.

10. Statement – The cost of providing more podiatric surgery posts in the NHS would be better spent on other aspects of health care.

Only 12 per cent disagreed with this statement. While just over 20 per cent were unsure, a large majority of 66 per cent did feel that finances would be better employed in areas other than podiatric surgery. I suggest in the following chapter that the most surprising finding here is the 12 per cent who disagreed. As the term 'other aspects of health care' is broad, one may have suspected that even more orthopaedic surgeons would view it more appropriate that resources were spent in providing health care other than in the form of podiatric surgery.

11. Statement – An increase in the availability of podiatric surgery in the NHS would increase levels of patient satisfaction.

The number of those who were unsure about this was virtually equal to those who ticked the Disagree box. However when the Disagree and Strongly Disagree categories are combined a majority of nearly 53 per cent is formed. Only 12 per cent considered levels of patient satisfaction would increase. The latter figure is low and may be taken to reflect orthopaedic surgeons' opinion of the effectiveness of podiatric surgery and the competence of podiatric surgeons which I discuss at some length in Chapter 7.

12. Statement – An increase in podiatric surgery within the NHS would result in more cases needing the attention of the orthopaedic surgeon.

The largest category responding to this statement was those who were unsure (33 per cent) but the majority (over 42 per cent) did agree. Over 25 per cent disagreed. As I indicated earlier, the responses to this statement are best viewed in conjunction with those to Statement 9.

13. Statement – An increase in podiatric surgery within the NHS would result in financial savings to the NHS.

A large majority of 62 per cent disagreed with this statement with less than 9 per cent in agreement. Once again a large percentage (30 per cent) was unsure. The responses to this statement may result from a lack of knowledge among orthopaedic surgeons about the benefits of podiatric surgery. The personal interviews would later reveal that few orthopaedic surgeons are familiar with published evidence about the cost-effectiveness of podiatric surgery.

Statements 14-17 relate to the merits of podiatric surgeons as practitioners.

14. Statement – Podiatric surgeons should not practise because they are not medically qualified.

Responses to this question were rather more evenly divided. Whilst the majority (46 per cent) agreed with this statement, nearly 20 per cent were unsure and 34 per cent disagreed. This may be considered surprising in light of the responses to the previous attitude questions. Also, responses were not closely related to attitudes I would later identify in the personal interviews. Here, disagreement with non-medically qualified personnel performing surgery was a recurrent theme.

15. Statement – Podiatric surgeons generally accept the scope and limitations of their work.

The highest category responding to this statement involved those who ticked the Agree box (30 per cent) and nearly 40 per cent agreed over all. Less than 32 per cent disagreed with the statement but a substantial figure of over 30 per cent were once again unsure. Perhaps these responses are indications of a general lack of knowledge among orthopaedic surgeons about podiatric surgeons which would later be identified through the personal interviews.

16. Statement – Podiatric surgeons should only practise under the guidance of an orthopaedic surgeon.

The majority of respondents agreed with this statement. Approaching 50 per cent felt that the orthopaedic surgeon should assume a superordinate position while the remainder were roughly split between those who disagreed and those who were unsure. This belief in the need for the 'superior' orthopaedic surgeon to supervise the podiatric surgeon was a recurrent theme in personal interviews and I later assert that it is a significant factor in orthopaedic attitudes towards podiatric surgeons (see Chapter 7).

17. Statement – Podiatric surgeons are suitably qualified and trained for the work they undertake.

The majority of respondents were divided about this; 39 per cent disagreed while an equal amount was unsure. Nearly 23 per cent agreed with the statement. As I discuss at some length in Chapter 7, many orthopaedic surgeons admitted in personal interviews that they know very little about the training or work of a podiatric surgeon; the responses to this statement may reflect that lack of knowledge.

Overall, the responses to statements 14-17 are probably less negative than those to statements 9-13 but, nevertheless, they do not suggest that orthopaedic surgeons have high regard for the capabilities of podiatric surgeons.

18. Podiatric scope of practice

With the questions assessing attitudes completed, the next question sought to establish how informed orthopaedic surgeons were with the scope of practice of the podiatric surgeon. This was done by defining the anatomical areas in which the podiatric surgeon could work. The results betrayed a distinct lack of understanding amongst orthopaedic surgeons. Podiatric surgery is confined to the whole foot but excluding the ankle joint and obviously, therefore, all areas above that. Nearly 60 per cent believed that podiatric surgery was limited to the forefoot only, and nearly 20 per cent thought podiatric surgeons could operate on the ankle. Two per cent even believed that operating on the knee by a podiatric surgeon was possible. Only just over 20 per cent correctly answered that podiatric surgery was confined to the forefoot and the hindfoot, leaving nearly 80 per cent revealing an erroneous conception of the

podiatric scope of practice. These results suggest that orthopaedic criticism of podiatric surgery may be misinformed in some important respects. I return to this possibility in the next chapter when I elaborate on the possible causes of this misconception.

19. Regulation of podiatric surgery

The next question asked whether an orthopaedic body should regulate podiatric surgery. Over 50 per cent thought it should, with 33 per cent disagreeing and 17 per cent unsure.

20. Following the last question, respondents were invited to explain the advantages of such regulation. Answers were analysed and categorised into themes which are summarised in the following two tables.

Advantages of regulation	Percentages of respondents answering the question *
Orthopaedic control of podiatric surgery generally	32
Integration of services	23
Better patient care	18
Uniformity of provision of service	13
Orthopaedic control of the scope of practice of the podiatric surgeon	13
Improved status of podiatrists	5

Table 5: Advantages of regulation of podiatric surgery by an orthopaedic body

* Rounded up to nearest full figure

Disadvantages of regulation	Percentage of respondents answering the question *
Orthopaedics should not take on this responsibility	71
Confusion regarding the role of the podiatric surgeon would increase	30

Table 6: Disadvantages of regulation of podiatric surgery by an orthopaedic body

*Rounded up to the nearest full figure

In this instance percentages are perhaps misleading and the use of numbers may be more appropriate; 17 respondents actually identified these disadvantages with 12 citing the former disadvantage and 5 the latter.

Overall these results indicate that orthopaedic surgeons would welcome control over podiatric surgeons. These findings are supported by personal interview results and will prove to be a key factor in my explanation of resistance by orthopaedics towards podiatric surgery (see Chapter 7).

21. Finally, respondents were invited to offer further comments on any aspect of the orthopaedic-podiatric surgeons relationship. Again responses were categorised into themes. Some themes such as 'denigration of the questionnaire' and 'flippant/insulting remarks' do not directly contribute to answering the research question though they may serve as an indication of hostility towards podiatric surgery. Some respondents assumed I was a podiatric surgeon and therefore directed some uncomplimentary remarks towards me. Results are shown in the following table.

Further comments	Percentage of those providing comments *
Objection to non-medically qualified persons performing surgery	45
Concern about the podiatric scope of practice	12
Objection to using the title 'surgeon'	11
Podiatrists lack the capabilities of the orthopaedic surgeon	10
Appreciation that orthopaedic surgeons are only likely to encounter podiatric failures	7
Ignorance regarding the regulation of podiatrists	7
Flippant/insulting remarks	6
Denigration of the questionnaire	5

Table 7: Further comments made by orthopaedic surgeons

* Rounded up to the nearest full figure

6.2 Crosstabulations

Crosstabulation tables, also known as contingency tables, can be employed to examine the relationship between two variables (usually nominal or ordinal) that have a small number of categories (Miller et al, 2002). Once data is transferred into a crosstabulation, interpretation involves looking for two features: pattern and strength (Argyrous, 2005). Pattern can be assessed as long as the variables are appropriately arranged in the formation of the table; the independent variable must run horizontally with values increasing from left to right whereas the dependent variable is placed vertically with values increasing

downwards. The modal call for each column is then highlighted and the results examined for a pattern, for example, as the value of the independent variable increases does also the value of the dependent variable? When both variables are ordinal, the pattern can be considered for direction and consistency. A positive relationship between the variables exists where movement along the scale of one variable in one direction is accompanied by movement in the same direction along the scale of the other variable. A negative relationship results when movement along the scale of one variable is accompanied by movement in the reverse direction along the scale of the other variable.

A consistent relationship occurs when the modal cells of a table show a smooth progression down a diagonal; an inconsistent relationship results when this pattern is not present, for example, a smooth progression down a diagonal is interrupted by the next modal cell which contains values siting it much higher within the table.

The strength of a relationship between two variables is determined by applying a measure of association, that is, a measure of association quantifies the extent to which a change in one variable relates to a change in the other variable. Measurements of association can be asymmetric or symmetric. The former describes the situation where it is believed that one variable is dependent on the other, and the latter where there is mutual dependence between the variables or when the dependent variable cannot be identified.

The measurement of association I applied to the current crosstabulations is Somers'*d* (Argyrous, 2005). This is an asymmetric measure which was appropriate in the circumstances to which it was applied, in other words, in all the crosstabulations I could determine a dependent variable. For example, attitudes amongst orthopaedic surgeons towards podiatric surgery provision within the NHS could be dependent on the number of podiatric surgery cases they had encountered whereas the reverse could not be argued. Somers'*d* can be employed when both variables are ordinal, which was true in all cases

here, and produces values between 1 and 0 (or -1 and 0); 1 would suggest a perfect association and 0 would infer no association at all (Argyrous, 2005).

6.2.2 Crosstabulations – orthopaedic surgeons

In this section each description of a crosstabulation is accompanied by the appropriate table as advocated by Argyrous (2005); the benefit of this to the reader is that any relationship embodied in a crosstabulation can be 'seen' by them and therefore they are not totally dependent on any accompanying written commentary. However, in order to improve presentation, I have not included either a table or a detailed commentary for crosstabulations which have failed to demonstrate a relationship between variables. For these, in all cases, I provide a short summary. Full details are included in the Appendices. Also, in order to improve presentation, and to make the section as succinct as possible, I have not included statistical tables for any crosstabulations, though I disclose results in my commentary. Statistical results together with the relevant crosstabulation tables can also be found in the Appendices.

My first use of crosstabulations was an attempt to determine if attitudes towards podiatric surgery amongst orthopaedic surgeons were formed as a result of their exposure to the results of podiatric surgery. The first nine crosstabulations therefore related the question of whether or not respondents had actually encountered the results of podiatric surgery to attitudes to be found amongst orthopaedic surgeons. Was it reasonable to assume that polarised opinions would result from such exposure, whereas neutral views were more likely to be found in those with no experience of results?

Crosstabulations found that any relationship between whether or not respondents have experience of podiatric surgery results and their attitudes regarding the place of podiatric surgery in the NHS (as assessed by the questions asked) is extremely weak. The same can

be said of attitudes towards podiatric surgeons as practitioners, that is, attitudes are not related to whether or not the respondent has experience of podiatric surgery results.

What of attitudes amongst those with such experience? Would attitudes change as respondents encountered an increased number of results and therefore became more appreciative of what podiatric surgery could offer? In an attempt to answer this question the next nine crosstabulations examined the relationship of attitudes with the number of podiatric surgery cases respondents had encountered. Once again no relationship was found between variables. It seems, therefore, that attitudes towards both the availability of podiatric surgery in the NHS and towards podiatric surgeons in general, are not influenced by a greater or lesser exposure to podiatric surgery results.

The next section of crosstabulations is shown in full. Here, attitudes were crosstabulated with orthopaedic surgeons' assessment of the technical results of the podiatric surgery results they had encountered. Would the presentation of favourable (or unfavourable) results make the orthopaedic surgeon more (or less) supportive of podiatric surgery?

1) An increase in the availability of podiatric surgery in the NHS would lead to a decrease in orthopaedic waiting lists crosstabulated with Technical results of cases encountered.

Increasing podiatric surgery in NHS would decrease orthopaedic waiting lists * Technical results Crosstabulation

			Technical results			
			mainly satisfactory	neither	mainly unsatisfactory	Total
Increasing podiatric surgery in NHS would decrease orthopaedic waiting lists	Strongly agree	Count	10	1	1	12
		% within Technical results	7.6%	2.1%	.6%	3.5%
	Agree	Count	54	8	25	87
		% within Technical results	40.9%	16.7%	15.5%	25.5%
	Neither agree nor disagree	Count	32	12	27	71
		% within Technical results	24.2%	25.0%	16.8%	20.8%
	Disagree	Count	31	21	61	113
		% within Technical results	23.5%	43.8%	37.9%	33.1%
	Strongly disagree	Count	5	6	47	58
		% within Technical results	3.8%	12.5%	29.2%	17.0%
Total		Count	132	48	161	341
		% within Technical results	100.0%	100.0%	100.0%	100.0%

Table 8: Crosstabulation 19

There does appear to be some relationship between these variables. The modal cells for those who have found favourable surgical results lies in the Agree section while for those who have found results to be unsatisfactory or Neither satisfactory nor unsatisfactory, it lies

in the Disagree section. The strength of the relationship is moderate with Somers'*d* value near to 0.4.

2) The cost of providing more podiatric surgery posts in the NHS would be better spent on other aspects of health-care crosstabulated with Technical results of cases encountered.

Costs of providing podiatric surgery better spent on other health care * Technical results Crosstabulation

			Technical results			Total
			mainly satisfactory	neither	mainly unsatisfactory	
Costs of providing podiatric surgery better spent on other health care	Strongly agree	Count	17	17	76	110
		% within Technical results	12.9%	35.4%	47.5%	32.4%
	Agree	Count	40	16	58	114
		% within Technical results	30.3%	33.3%	36.3%	33.5%
	Neither agree nor disagree	Count	40	10	17	67
		% within Technical results	30.3%	20.8%	10.6%	19.7%
	Disagree	Count	31	4	8	43
		% within Technical results	23.5%	8.3%	5.0%	12.6%
	Strongly disagree	Count	4	1	1	6
		% within Technical results	3.0%	2.1%	.6%	1.8%
Total		Count	132	48	160	340
		% within Technical results	100.0%	100.0%	100.0%	100.0%

Table 9: Crosstabulation 20

Again, the quality of the technical results does seem to affect attitudes. Those finding results unsatisfactory or neither satisfactory nor unsatisfactory strongly believe other

aspects of health-care are more deserving of funding than podiatric surgery whereas those who deem the results to be satisfactory either agree or neither agree nor disagree. The relationship is again of moderate strength with a value close to 0.4.

3) An increase in the availability of podiatric surgery in the NHS would increase levels of patient satisfaction crosstabulated with Technical results of cases encountered.

Increasing podiatric surgery in NHS would increase patient satisfaction * Technical results Crosstabulation

			Technical results			Total
			mainly satisfactory	neither	mainly unsatisfactory	
Increasing podiatric surgery in NHS would increase patient satisfaction	Strongly agree	Count	4	0	0	4
		% within Technical results	3.0%	.0%	.0%	1.2%
	Agree	Count	32	3	4	39
		% within Technical results	24.2%	6.3%	2.5%	11.4%
	Neither agree nor disagree	Count	52	17	26	95
		% within Technical results	39.4%	35.4%	16.1%	27.9%
	Disagree	Count	37	21	71	129
		% within Technical results	28.0%	43.8%	44.1%	37.8%
	Strongly disagree	Count	7	7	60	74
		% within Technical results	5.3%	14.6%	37.3%	21.7%
Total		Count	132	48	161	341
		% within Technical results	100.0%	100.0%	100.0%	100.0%

Table 10: Crosstabulation 21

The modal cell for those who have found favourable results lies in the Neither agree nor disagree section but for those finding results neither satisfactory nor unsatisfactory or

mainly unsatisfactory, modal cells are found under Disagree. There is, therefore, some relationship between these variables with a slightly higher Somers'*d* value of approaching 0.5.

4) An increase in podiatric surgery within the NHS would result in more cases needing the attention of the orthopaedic surgeon crosstabulated with Technical results of cases encountered.

Increasing podiatric surgery in NHS would increase orthopaedic surgery caseload * Technical results Crosstabulation

			Technical results			Total
			mainly satisfactory	neither	mainly unsatisfactory	
Increasing podiatric surgery in NHS would increase orthopaedic surgery caseload	Strongly agree	Count	2	4	51	57
		% within Technical results	1.5%	8.3%	31.9%	16.8%
	Agree	Count	32	18	58	108
		% within Technical results	24.2%	37.5%	36.3%	31.8%
	Neither agree nor disagree	Count	37	20	36	93
		% within Technical results	28.0%	41.7%	22.5%	27.4%
	Disagree	Count	54	6	14	74
		% within Technical results	40.9%	12.5%	8.8%	21.8%
	Strongly disagree	Count	7	0	1	8
		% within Technical results	5.3%	.0%	.6%	2.4%
Total		Count	132	48	160	340
		% within Technical results	100.0%	100.0%	100.0%	100.0%

Table 11: Crosstabulation 22

Here there is a consistent negative relationship between the variables of moderate strength (0.4 in value). For those who have experienced mainly unsatisfactory results the modal cell lies within the Agree category, for those who have found neither satisfactory nor unsatisfactory results the modal cell sits in the Neither agree nor disagree section, and for those who consider results mainly satisfactory the modal cell equates to Disagree. Therefore whether respondents believe that increasing podiatric surgery within the NHS would cause more work for orthopaedic surgeons relates somewhat to the type of technical results experienced.

5) An increase in podiatric surgery within the NHS would result in financial savings to the NHS crosstabulated with Technical result of cases encountered.

Increasing podiatric surgery in NHS would result in financial savings for NHS * Technical results Crosstabulation

			Technical results			
			mainly satisfactory	neither	mainly unsatisfactory	Total
Increasing podiatric surgery in NHS would result in financial savings for NHS	Strongly agree	Count	2	0	0	2
		% within Technical results	1.5%	.0%	.0%	.6%
	Agree	Count	21	1	7	29
		% within Technical results	15.9%	2.1%	4.3%	8.5%
	Neither agree nor disagree	Count	54	17	27	98
		% within Technical results	40.9%	35.4%	16.7%	28.7%
	Disagree	Count	47	21	73	141
		% within Technical results	35.6%	43.8%	45.1%	41.2%
	Strongly disagree	Count	8	9	55	72
		% within Technical results	6.1%	18.8%	34.0%	21.1%
Total		Count	132	48	162	342
		% within Technical results	100.0%	100.0%	100.0%	100.0%

Table 12: Crosstabulation 23

There is a moderate strength (nearly 0.4) relationship between the variables; the modal cell for those experiencing satisfactory results lies in the Neither agree or disagree section whilst modal cells for the other two categories are found in Disagree. Views on the financial merits to the NHS of podiatric surgery results do, therefore, relate somewhat to technical results encountered.

Crosstabulations 19 – 23 Summary

Attitudes towards provision of podiatric surgery within the NHS could be somewhat influenced by the technical results of the cases respondents have encountered. The trend is that, the better that technical results are perceived, the more favourable the attitude towards podiatric surgery. It would appear that attitudes may be influenced, though not determined, by these results as the relationship is only of moderate strength.

The next four tables crosstabulate attitudes towards podiatric surgeons with technical results encountered.

6) Podiatric surgeons should not practise because they are not medically qualified practitioners crosstabulated with Technical results of cases encountered.

Podiatric surgeons should not practise because not medically qualified * Technical results Crosstabulation

			Technical results			Total
			mainly satisfactory	neither	mainly unsatisfactory	
Podiatric surgeons should not practise because not medically qualified	Strongly agree	Count	8	12	69	89
		% within Technical results	6.2%	25.0%	43.4%	26.5%
	Agree	Count	22	11	41	74
		% within Technical results	17.1%	22.9%	25.8%	22.0%
	Neither agree nor disagree	Count	20	10	17	47
		% within Technical results	15.5%	20.8%	10.7%	14.0%
	Disagree	Count	73	13	32	118
		% within Technical results	56.6%	27.1%	20.1%	35.1%
	Strongly disagree	Count	6	2	0	8
		% within Technical results	4.7%	4.2%	.0%	2.4%
Total		Count	129	48	159	336
		% within Technical results	100.0%	100.0%	100.0%	100.0%

Table 13: Crosstabulation 24

With modal cells for the mainly satisfactory and neither satisfactory nor unsatisfactory categories lying within Disagree and the modal cell for mainly unsatisfactory to be found in Strongly agree, there is an inconsistent relationship. However, this relationship is

moderately strong with Somers'*d* level approaching 0.5. Views on eligibility of podiatric surgeons to practise may be influenced by technical results encountered.

7) Podiatric surgeons generally accept the scope and limitations of their work crosstabulated with Technical results of cases encountered.

Podiatric surgeons accept scope and limitations of their work * Technical results Crosstabulation

			Technical results			Total
			mainly satisfactory	neither	mainly unsatisfactory	
Podiatric surgeons accept scope and limitations of their work	Strongly agree	Count	11	7	24	42
		% within Technical results	8.3%	14.6%	15.0%	12.4%
	Agree	Count	68	11	27	106
		% within Technical results	51.5%	22.9%	16.9%	31.2%
	Neither agree nor disagree	Count	21	14	20	55
		% within Technical results	15.9%	29.2%	12.5%	16.2%
	Disagree	Count	31	14	52	97
		% within Technical results	23.5%	29.2%	32.5%	28.5%
	Strongly disagree	Count	1	2	37	40
		% within Technical results	.8%	4.2%	23.1%	11.8%
Total		Count	132	48	160	340
		% within Technical results	100.0%	100.0%	100.0%	100.0

Table 14: Crosstabulation 25

The modal cell for mainly satisfactory lies in Agree, for Neither satisfactory nor unsatisfactory it lies in Neither agree or disagree, and for mainly unsatisfactory it is found in Disagree. Were it not for the fact that the mode for Neither satisfactory nor

unsatisfactory is repeated in the Disagree section, there would be a consistent positive relationship. The strength of the relationship that exists is only weak to moderate (less than 0.3) but it does seem that the type of technical results encountered has some effect on whether respondents feel podiatric surgeons accept their limitations.

8) Podiatric surgeons should only practise under the guidance of an orthopaedic surgeon crosstabulated with Technical results encountered.

Podiatric surgeons should only practise under guidance of an orthopaedic surgeon * Technical results Crosstabulation

			Technical results			Total
			mainly satisfactory	Neither	mainly unsatisfactory	
Podiatric surgeons should only practise under guidance of an orthopaedic surgeon	Strongly agree	Count	20	12	41	73
		% within Technical results	15.2%	25.5%	25.8%	21.6%
	Agree	Count	33	13	50	96
		% within Technical results	25.0%	27.7%	31.4%	28.4%
	Neither agree nor disagree	Count	34	13	29	76
		% within Technical results	25.8%	27.7%	18.2%	22.5%
	Disagree	Count	42	8	21	71
		% within Technical results	31.8%	17.0%	13.2%	21.0%
	Strongly disagree	Count	3	1	18	22
		% within Technical results	2.3%	2.1%	11.3%	6.5%
Total		Count	132	47	159	338
		% within Technical results	100.0%	100.0%	100.0%	100.0%

Table 15: Crosstabulation 26

The modal cells lie as follows: for mainly satisfactory – Disagree, for neither satisfactory nor unsatisfactory – Agree but repeated in Neither agree nor disagree, and for mainly unsatisfactory – Agree. Were it not for the repetition of the Neither satisfactory nor unsatisfactory category there would be a consistent negative relationship. However, the relationship present is weak (close to 0.1) so technical results encountered do not seem to have much of an influence on views regarding supervision of podiatric surgeons by orthopaedic surgeons.

9) Podiatric surgeons are suitably qualified and trained for the work they undertake crosstabulated with Technical results encountered.

Podiatric surgeons are suitably qualified and trained for work undertaken * Technical results Crosstabulation

			Technical results			Total
			mainly satisfactory	neither	mainly unsatisfactory	
Podiatric surgeons are suitably qualified and trained for work undertaken	Strongly agree	Count	12	3	1	16
		% within Technical results	9.1%	6.3%	.6%	4.7%
	Agree	Count	47	5	15	67
		% within Technical results	35.6%	10.4%	9.3%	19.6%
	Neither agree nor disagree	Count	47	18	29	94
		% within Technical results	35.6%	37.5%	18.0%	27.6%
	Disagree	Count	24	16	61	101
		% within Technical results	18.2%	33.3%	37.9%	29.6%
	Strongly disagree	Count	2	6	55	63
		% within Technical results	1.5%	12.5%	34.2%	18.5%
Total		Count	132	48	161	341
		% within Technical results	100.0%	100.0%	100.0%	100.0%

Table 16: Crosstabulation 27

In the mainly satisfactory category the modal cell is found in Agree but is repeated in Neither agree nor disagree. Neither satisfactory nor unsatisfactory has its modal cell in Neither agree nor disagree while in mainly unsatisfactory the modal cell lies in the Disagree section. The repetition of a modal cell alters the pattern slightly from a consistent positive

relationship. The relationship is moderately strong (over 0.5) so views on the suitability of podiatric surgeons for the work undertaken could be influenced by respondent's experience of technical results.

Crosstabulations 24 – 27 Summary

As with attitudes towards provision of podiatric surgery within the NHS, views on podiatric surgeons as a discipline could be influenced in a moderate way by technical results of surgery experienced by orthopaedic surgeons. Those who regard technical results as mainly satisfactory are more inclined to view podiatric surgeons favourably. As it seems that attitudes amongst orthopaedic surgeons may be affected by their assessment of technical results, could one also expect opinions to alter in relation to perception of patient satisfaction? The final section of crosstabulations involving the results of the orthopaedic surgeons' questionnaire therefore attempts to discover if this is so.

10) An increase in the availability of podiatric surgery in the NHS would lead to a decrease in orthopaedic waiting lists crosstabulated with Patient satisfaction.

Increasing podiatric surgery in NHS would decrease orthopaedic waiting lists * Patient satisfaction Crosstabulation

			Patient satisfaction			
			mainly satisfactory	neither	mainly unsatisfactory	Total
Increasing podiatric surgery in NHS would decrease orthopaedic waiting lists	Strongly agree	Count	10	1	1	12
		% within Patient satisfaction	7.6%	2.1%	.6%	3.6%
	Agree	Count	51	10	26	87
		% within Patient satisfaction	38.6%	21.3%	16.6%	25.9%
	Neither agree nor disagree	Count	32	12	24	68
		% within Patient satisfaction	24.2%	25.5%	15.3%	20.2%
	Disagree	Count	34	17	62	113
		% within Patient satisfaction	25.8%	36.2%	39.5%	33.6%
	Strongly disagree	Count	5	7	44	56
		% within Patient satisfaction	3.8%	14.9%	28.0%	16.7%
Total		Count	132	47	157	336
		% within Patient satisfaction	100.0%	100.0%	100.0%	100.0%

Table 17: Crosstabulation 28

The modal cells for those who found patients mainly dissatisfied or neither satisfied or dissatisfied are found under Disagree, whilst that for those who found patients to be mainly satisfied lies in the Agree section. The somewhat inconsistent relationship has a moderate value of nearly 0.4 suggesting there is something of a link between perception of patient

satisfaction and views on the effect on orthopaedic waiting lists of increasing podiatric surgery provision.

11) The cost of providing more podiatry surgery posts in the NHS would be better spent on other aspects of health-care crosstabulated with Patient satisfaction.

Costs of providing podiatric surgery better spent on other health care * Patient satisfaction Crosstabulation

			Patient satisfaction			Total
			mainly satisfactory	neither	mainly unsatisfactory	
Costs of providing podiatric surgery better spent on other health care	Strongly agree	Count	18	15	75	108
		% within Patient satisfaction	13.6%	31.9%	48.1%	32.2%
	Agree	Count	38	19	55	112
		% within Patient satisfaction	28.8%	40.4%	35.3%	33.4%
	Neither agree nor disagree	Count	40	8	19	67
		% within Patient satisfaction	30.3%	17.0%	12.2%	20.0%
	Disagree	Count	31	4	7	42
		% within Patient satisfaction	23.5%	8.5%	4.5%	12.5%
	Strongly disagree	Count	5	1	0	6
		% within Patient satisfaction	3.8%	2.1%	.0%	1.8%
Total		Count	132	47	156	335
		% within Patient satisfaction	100.0%	100.0%	100.0%	100.

Table 18: Crosstabulation 29

Modal cells are as follows: The mainly satisfactory category lies in Neither agree nor disagree, neither satisfactory nor unsatisfactory is found in Agree, and mainly

unsatisfactory sits in Strongly Agree. A consistent negative relationship is thus formed with a moderately strong value of just under 0.5. There is, then, some link between perceived patient satisfaction levels and views on the relative value of providing more podiatric surgery posts in the NHS.

12) An increase in the availability of podiatric surgery in the NHS would increase levels of patient satisfaction crosstabulated with Patient satisfaction.

Increasing podiatric surgery in NHS would increase patient satisfaction * Patient satisfaction Crosstabulation

			Patient satisfaction			Total
			mainly satisfactory	neither	mainly unsatisfactory	
Increasing podiatric surgery in NHS would increase patient satisfaction	Strongly agree	Count	4	0	0	4
		% within Patient satisfaction	3.0%	.0%	.0%	1.2%
	Agree	Count	32	3	5	40
		% within Patient satisfaction	24.2%	6.4%	3.2%	11.9%
	Neither agree nor disagree	Count	52	18	23	93
		% within Patient satisfaction	39.4%	38.3%	14.6%	27.7%
	Disagree	Count	36	18	73	127
		% within Patient satisfaction	27.3%	38.3%	46.5%	37.8%
	Strongly disagree	Count	8	8	56	72
		% within Patient satisfaction	6.1%	17.0%	35.7%	21.4%
Total		Count	132	47	157	336
		% within Patient satisfaction	100.0%	100.0%	100.0%	100.0%

Table 19: Crosstabulation 30

Perhaps rather surprisingly, the modal cell for those who had found patients to be mainly satisfied fell in the Neither agree nor disagree section. Those who had found patients mainly unsatisfied created a mode lying in the Disagree section and the mode of those who found patients were neither satisfied nor dissatisfied was duplicated in the Neither agree nor disagree and the Disagree sections. The result is a not entirely consistent relationship but one which displays moderate strength of approaching 0.5. There is, therefore, a relationship between perception of patient satisfaction levels and views on whether increasing podiatric surgery provision in the NHS would increase levels of patient satisfaction.

13) An increase in the availability of podiatric surgery within the NHS would result in more cases needing the attention of the orthopaedic surgeon crosstabulated with Patient satisfaction.

Increasing podiatric surgery in NHS would increase orthopaedic surgery caseload * Patient satisfaction Crosstabulation

			Patient satisfaction			Total
			mainly satisfactory	neither	mainly unsatisfactory	
Increasing podiatric surgery in NHS would increase orthopaedic surgery caseload	Strongly agree	Count	3	6	46	55
		% within Patient satisfaction	2.3%	12.8%	29.5%	16.4%
	Agree	Count	33	14	61	108
		% within Patient satisfaction	25.0%	29.8%	39.1%	32.2%
	Neither agree nor disagree	Count	39	19	32	90
		% within Patient satisfaction	29.5%	40.4%	20.5%	26.9%
	Disagree	Count	50	8	16	74
		% within Patient satisfaction	37.9%	17.0%	10.3%	22.1%
	Strongly disagree	Count	7	0	1	8
		% within Patient satisfaction	5.3%	.0%	.6%	2.4%
Total		Count	132	47	156	335
		% within Patient satisfaction	100.0%	100.0%	100.0%	100.0%

Table 20: Crosstabulation 31

There is a consistent negative relationship here. Modal cells are as follows: mainly unsatisfactory – Agree, neither satisfactory nor unsatisfactory – Neither agree nor disagree, and mainly satisfactory – Disagree. The strength of the relationship is moderately strong at

nearly 0.5. Therefore, views on whether increased podiatric surgery provision would create more work for orthopaedics does relate to a certain extent to perceived levels of patient satisfaction.

14) An increase in podiatric surgery within the NHS would result in financial savings to the NHS crosstabulated with Patient satisfaction.

Increasing podiatric surgery in NHS would result in financial savings for NHS * Patient satisfaction Crosstabulation

			Patient satisfaction			Total
			mainly satisfactory	neither	mainly unsatisfactory	
Increasing podiatric surgery in NHS would result in financial savings for NHS	Strongly agree	Count	2	0	0	2
		% within Patient satisfaction	1.5%	.0%	.0%	.6%
	Agree	Count	20	1	8	29
		% within Patient satisfaction	15.2%	2.1%	5.1%	8.6%
	Neither agree nor disagree	Count	51	16	28	95
		% within Patient satisfaction	38.6%	34.0%	17.7%	28.2%
	Disagree	Count	49	19	74	142
		% within Patient satisfaction	37.1%	40.4%	46.8%	42.1%
	Strongly disagree	Count	10	11	48	69
		% within Patient satisfaction	7.6%	23.4%	30.4%	20.5%
Total		Count	132	47	158	337
		% within Patient satisfaction	100.0%	100.0%	100.0%	100.0%

Table 21: Crosstabulation 32

For those who have found mainly satisfied patients, the modal cell lies in the Neither agree nor disagree section and for the other two categories it is found under Disagree. The relationship is not particularly strong at just over 0.3 but it seems that views on the financial benefit to the NHS of podiatric surgery relate, in some way, to perceived levels of patient satisfaction.

Crosstabulations 28 – 32 Summary

With every question that has sought to assess respondents' attitudes regarding podiatric surgery provision within the NHS, there appears to be some relationship with the perception of levels of patient satisfaction with podiatric surgery they have received. The strength of that relationship varies from weak – moderate (0.3) to moderately strong (0.5) and the tendency is that the higher respondents view patients satisfaction from having received podiatric surgery, the more inclined the respondent is to view podiatric surgery favourably.

The final four crosstabulations examine the relationship between attitudes towards podiatric surgeons and perceived levels of patient satisfaction.

15) Podiatric surgeons should not practise because they are not medically qualified practitioners crosstabulated with Patient satisfaction.

Podiatric surgeons should not practise because not medically qualified * Patient satisfaction Crosstabulation

			Patient satisfaction			Total
			mainly satisfactory	neither	mainly unsatisfactory	
Podiatric surgeons should not practise because not medically qualified	Strongly agree	Count	13	12	61	86
		% within Patient satisfaction	9.9%	25.0%	40.1%	26.0%
	Agree	Count	22	8	42	72
		% within Patient satisfaction	16.8%	16.7%	27.6%	21.8%
	Neither agree nor disagree	Count	19	8	19	46
		% within Patient satisfaction	14.5%	16.7%	12.5%	13.9%
	Disagree	Count	71	18	30	119
		% within Patient satisfaction	54.2%	37.5%	19.7%	36.0%
	Strongly disagree	Count	6	2	0	8
		% within Patient satisfaction	4.6%	4.2%	.0%	2.4%
Total		Count	131	48	152	331
		% within Patient satisfaction	100.0%	100.0%	100.0%	100.0%

Table 22: Crosstabulation 33

The modal cell for those finding patients to be mainly dissatisfied lies in the Strongly agree section and for the other two categories it is found under Disagree. The relationship is not particularly consistent but moderately strong at 0.4 in value. There is therefore, some relationship between views on eligibility of podiatric surgeons to practise without holding a medical qualification, and perceived levels of patient satisfaction.

16) Podiatric surgeons generally accept the scope and limitations of their work crosstabulated with Patient satisfaction.

Podiatric surgeons accept scope and limitations of their work * Patient satisfaction Crosstabulation						
			Patient satisfaction			Total
			mainly satisfactory	neither	mainly unsatisfactory	
Podiatric surgeons accept scope and limitations of their work	Strongly agree	Count	10	6	26	42
		% within Patient satisfaction	7.6%	12.8%	16.7%	12.5%
	Agree	Count	67	13	26	106
		% within Patient satisfaction	50.8%	27.7%	16.7%	31.6%
	Neither agree nor disagree	Count	23	10	21	54
		% within Patient satisfaction	17.4%	21.3%	13.5%	16.1%
	Disagree	Count	28	14	54	96
		% within Patient satisfaction	21.2%	29.8%	34.6%	28.7%
	Strongly disagree	Count	4	4	29	37
		% within Patient satisfaction	3.0%	8.5%	18.6%	11.0%
Total		Count	132	47	156	335
		% within Patient satisfaction	100.0%	100.0%	100.0%	100.0%

Table 23: Crosstabulation 34

There is a fairly consistent positive relationship with modal cells as follows: mainly satisfactory – Agree, neither satisfactory nor unsatisfactory – Disagree, mainly unsatisfactory – Strongly disagree. However this is not a strong relationship, with a value

of just over 0.2. Therefore, views on limitations accepted by podiatric surgeons are only mildly related to perceived levels of patient satisfaction.

17) Podiatric surgeons should only practise under the guidance of an orthopaedic surgeon crosstabulated with Patient satisfaction.

Podiatric surgeons should only practise under guidance of an orthopaedic surgeon * Patient satisfaction Crosstabulation

			Patient satisfaction			Total
			mainly satisfactory	neither	mainly unsatisfactory	
Podiatric surgeons should only practise under guidance of an orthopaedic surgeon	Strongly agree	Count	22	9	40	71
		% within Patient satisfaction	16.7%	19.6%	25.8%	21.3%
	Agree	Count	34	13	48	95
		% within Patient satisfaction	25.8%	28.3%	31.0%	28.5%
	Neither agree nor disagree	Count	32	14	29	75
		% within Patient satisfaction	24.2%	30.4%	18.7%	22.5%
	Disagree	Count	40	9	22	71
		% within Patient satisfaction	30.3%	19.6%	14.2%	21.3%
	Strongly disagree	Count	4	1	16	21
		% within Patient satisfaction	3.0%	2.2%	10.3%	6.3%
Total		Count	132	46	155	333
		% within Patient satisfaction	100.0%	100.0%	100.0%	100.0%

Table 24: Crosstabulation 35

There is a consistent negative relationship here with the modal cell for mainly unsatisfactory appearing in the Agree section, that for neither satisfactory nor satisfactory

lying in the Neither agree nor disagree section, and that for mainly satisfactory to be found under Disagree. However the relationship is a weak one, with a value of just over 0.1. Therefore, there is a minimal relationship between views on supervision of podiatric surgeons by orthopaedic surgeons and perceived levels of patient satisfaction.

18) Podiatric surgeons are suitably qualified and trained for the work they undertake crosstabulated with Patient satisfaction.

Podiatric surgeons are suitably qualified and trained for work undertaken * Patient satisfaction Crosstabulation

			Patient satisfaction			
			mainly satisfactory	neither	mainly unsatisfactory	Total
Podiatric surgeons are suitably qualified and trained for work undertaken	Strongly agree	Count	11	3	2	16
		% within Patient satisfaction	8.3%	6.4%	1.3%	4.8%
	Agree	Count	46	8	13	67
		% within Patient satisfaction	34.8%	17.0%	8.3%	19.9%
	Neither agree nor disagree	Count	44	16	33	93
		% within Patient satisfaction	33.3%	34.0%	21.0%	27.7%
	Disagree	Count	27	14	58	99
		% within Patient satisfaction	20.5%	29.8%	36.9%	29.5%
	Strongly disagree	Count	4	6	51	61
		% within Patient satisfaction	3.0%	12.8%	32.5%	18.2%
Total		Count	132	47	157	336
		% within Patient satisfaction	100.0%	100.0%	100.0%	100.0%

Table 25: Crosstabulation 36

With the modal cell for mainly satisfactory appearing under Strongly agree, that for neither satisfactory nor unsatisfactory to be found under Neither agree nor disagree, and that for mainly unsatisfactory lying in the Disagree section, there is a consistent positive relationship with a value of nearly 0.5. Therefore, there is a moderately strong relationship

between views on the suitability of podiatric surgeons to undertake their work and perceived levels of patient satisfaction.

Crosstabulations 33-36 Summary

As with views on the provision of podiatric surgery in the NHS, opinions on podiatric surgeons as a body do seem to relate to perceived levels of patient satisfaction following podiatric surgery. However, the strength of relationships in the latter section is slightly lower than the former and ranges from 0.1 – 0.5. The trend, then, is for the orthopaedic surgeon to be more favourably inclined towards podiatric surgery when he has more experience of what he perceives to be higher levels of patient satisfaction following surgery.

6.3 Frequencies – podiatric surgeons

1) Gender

gender

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	male	77	77.0	77.0	77.0
	female	23	23.0	23.0	100.0
	Total	100	100.0	100.0	

Table 26: Gender of podiatric surgeons

The previous table shows that, as with orthopaedics, males dominate the profession of podiatric surgery. However, in the latter profession females are more strongly represented and form nearly 25 per cent of the population. Having established that both disciplines are male dominated, I am able to consider Willis' (1994) theory of gender and subordination in the next chapter.

2) Age

At just under 46 the mean age of the podiatric surgeon is slightly lower than that of the orthopaedic surgeon (50+). Age profiles compare with orthopaedics in that there are no podiatric surgeons aged below 30 and the highest percentage is found in the 40 – 49 age band (42 per cent). Also, a small percentage (3 per cent) is found in the 70+ age bracket but, as with orthopaedics, these are unlikely to still be practising. Greater detail of ages can be found in Appendices. The greater number of podiatric surgeons to be found in the 30 – 39 age range, compared with orthopaedic surgeons is worthy of discussion, and I consider this in the next chapter.

3) Geography

The geographical distribution of podiatric surgeons bears comparison with that of orthopaedic surgeons; the highest proportion of podiatric surgeons is found in the south-east of England and one of the lowest representations is seen in the north-east. At the time of collecting data for this study there were no podiatric surgeons at all in Scotland. This, however, may have changed slightly by the time of writing through a new initiative for training podiatric surgeons in Scotland. I will return to this consideration in Chapter 7 and also discuss the implications of this new initiative in Scotland for future research in Chapter 8. Also, in the next chapter, I am able to compare the geographical distribution of both

orthopaedic and podiatric surgeons in terms of numbers and postulate on what effect this may have on interprofessional relations.

4) Experience of professional contact with orthopaedic surgery.

At 90 per cent, the majority of podiatric surgeons have experienced some form of professional contact with orthopaedic surgeons. With regard to the fairly substantial figure of 10 per cent who do not, see below.

5) Number of surgery sessions held in a typical month.

The highest percentage of surgeons undertakes between 8 and 14 sessions per month (29 per cent) and only 6 per cent hold more than 22. With 10 per cent of subjects surgically inactive and 41 per cent undertaking less than 7 sessions per month, over half the profession shows low activity levels. To those not closely familiar with podiatry it may seem odd that such a large number of podiatric surgeons are so unproductive. This can be explained by the fact that most surgeons do not engage exclusively in theatre work but spend part of their working time as clinical podiatrists. Also 3 of the 10 who do not operate at all are aged 70+ and likely to have retired. More importantly, perhaps, the high percentage of the population showing low activity levels may account for the fairly significant figure of 10 per cent who have had no form of professional contact with orthopaedics. One could explain this simply on the basis that the smaller amount of surgery a podiatric surgeon undertakes, the less likely he or she is to come to the attention of the local orthopaedic surgeons. Furthermore, I believe most surgeons would agree that the more surgery one undertakes the more likely one is to encounter surgical complications. In the further comments section of the orthopaedics questionnaire the point was made that orthopaedic surgeons are only likely to see failed podiatric surgery results. It therefore

follows that low podiatric surgery activity levels may produce low levels of contact with orthopaedics.

6) Nature of the professional contact.

The highest category, at 33 per cent, involves those who have found the contact satisfactory. Roughly half the respondents found contact to be satisfactory or very satisfactory. This leaves the other half who believe the contact to be less satisfactory though it should be noted that 29 per cent cannot decide if the contact has been satisfactory or not.

7) Nature of the satisfactory contact.

The following table shows the results of this question. Overall the key to this satisfactory professional interaction seems to be some form of integration of orthopaedic and podiatric surgical services. This type of collaboration may result in such benefits as joint consultations and reciprocal referrals. This may have significance if the relationship between the two disciplines is to be improved and forms the basis of recommendations I make in Chapter 8.

Nature of contact	Percentage of cases *
Generally supportive	24
Integrated service	20
Reciprocal referrals	20
Joint consultations	18
Referrals	9
Positive communication	9
Reciprocal training	3

Table 27: Nature of contact podiatric surgeons have experienced with orthopaedic surgeons

* Percentage rounded up to nearest full figure

8) Advantages of this satisfactory contact.

From the following table one can see that, from the podiatric surgeon's point of view, the biggest benefit from satisfactory contact with orthopaedic surgeons is improved care for the patient (30 per cent). Over 25 per cent cite professional interaction as the next biggest advantage, though this is a vague term and could encompass most of the other categories.

Advantage	Percentage of cases *
Improved patient care	30
Professional interaction	26
Exchange of ideas and working practices	18
Access to other services	14
Expansion of knowledge	9
Potential for expansion of practice	3

Table 28: Perceived advantages by podiatric surgeons of having satisfactory contact with orthopaedic surgeons

*Percentage rounded up to nearest full figure

9) Disadvantages of this satisfactory contact.

There were a small number of respondents who identified disadvantages of this contact – see following table. Twenty five per cent (though only 2 in number) noted the problem of orthopaedics attempting to exert control over their practice.

Disadvantages	Percentage of cases *
Orthopaedic control	25
Conflict within orthopaedics	25
Lack of support from own professional body	13
Disapproval from peers	13
Techniques challenged	13
No disadvantages to be seen	13

Table 29: Perceived disadvantages by podiatric surgeons of having satisfactory contact with orthopaedic surgeons

* Percentage rounded up to nearest full figure

10) Nature of unsatisfactory contact.

The table below displays a range of activities directed against podiatric surgeons by orthopaedic surgeons. The highest category involves an unwillingness to interact (over 26 per cent) and, perhaps of greater practical significance, over 20 per cent of respondents have met with attempts by orthopaedic surgeons to obstruct the service they provide.

Nature of activity	Percentage of cases *
Unwillingness to interact	27
Obstruction to services	21
Suspicion/hostility	21
Incitement to litigation	12
Providing misinformation to patients	10
Personal insults	6
Complaints to management/purchasers	6

Table 30: Nature of unsatisfactory contact podiatric surgeons have experienced with orthopaedic surgeons

* Percentage rounded up to nearest full figure

11) Strategies to overcome unsatisfactory contact.

Those who have met with unsatisfactory contact have developed a range of strategies to deal with it. Few have opted for confrontation (8 per cent); instead over 26 per cent have attempted to improve communication with orthopaedic surgeons and over 20 per cent have resolved to maintain their professionalism in the face of unsatisfactory contact. With orthopaedic opposition, 4 per cent have actually decided to decrease their scope of practice.

12) Establishing a more formal working relationship between podiatric and orthopaedic surgeons.

Nearly 90 per cent of podiatric surgeons are in favour of improving relations with orthopaedic surgeons. Only 3 per cent actually find the prospect undesirable or very undesirable. Again, this has significance when recommending ways of improving the interprofessional relationship.

13) Reasons for answers to the above question.

Reasons given for views on whether or not a more formal working relationship with orthopaedics should be adopted are shown in the following table. Three reasons were given why such a relationship would be unfavourable: seven per cent had fears for their autonomy and, possibly related, one respondent (0.7 per cent) feared for his/her scope of practice. Two respondents (1.5 per cent) simply stated they could see no benefit. Of those who viewed an improved relationship positively, over 26 per cent felt the biggest advantage would be to increase mutual respect and understanding, closely followed by those who saw potential improvement to patient care.

Reason for answer	Percentage of cases *
Increase mutual respect and understanding	27
Improved patient care	24
Better integration into the NHS	11
Improved scope of practice	10
Expansion of knowledge	9
Fears for autonomy	7
Improved professional image	6
Improved training	3
Increases workload	2
Improved NHS surgical structure	2
Improved research possibilities	1
Fears for scope of practice	1

Table 31: Reasons given by podiatric surgeons for advocating or not advocating the development of a more formal working relationship with orthopaedic surgeons

* Percentage rounded up to nearest full figure

14) Working under the direction of orthopaedics.

Podiatrists are generally not in favour of this. Fifty seven per cent would not consider working under the direction of orthopaedics in a dedicated foot care team with a further 9 per cent unsure. Only 10 per cent would consider the possibility, while a further 24 per cent might give it consideration.

15) Reasons given for the answers to the question above.

The biggest issue for respondents revolves around subservience, that is, they are unwilling to become subservient to orthopaedics, with over 70 per cent making this point. Forty per cent of those answering this question expanded on their views by indicating a willingness to work with orthopaedics but only on a partnership basis. A further 4 per cent made the comment that working under the direction of orthopaedics would maintain medical dominance which is probably another way of saying they, too, are against subservience.

16) Further comments.

Only a few further comments were made and in such small numbers they add little of value. A full table can be seen in the Appendices.

6.4 Crosstabulations – podiatric surgeons

I undertook four crosstabulations using the data collected from the podiatric surgeons' questionnaires. Firstly, I crosstabulated the degree of satisfaction with orthopaedic surgery contact with the number of surgery sessions held in a typical month. The intention was to discover if the nature of contact changed when the amount of podiatric surgery undertaken increased. A reasonable assumption might be that the more surgery a podiatrist undertakes, the more likely he or she is to attract the attention of the local orthopaedic surgeons; as a result more resistance could be encountered or, alternatively, the orthopaedic surgeon might respond with a greater degree of support.

The strength of any relationship was found to be very weak and so it seems that the amount of podiatric surgery undertaken has no bearing on the relationship between local podiatric and orthopaedic surgeons.

The second crosstabulation attempted to relate the willingness among podiatric surgeons to work under orthopaedic surgeons, to the degree of satisfactory contact with them they had previously experienced. Here, my assumption was that the more satisfactory the contact experienced, the more agreeable would seem the prospect of working under orthopaedic direction. Once again, only a weak relationship was found to exist, suggesting that podiatric surgeons' views regarding such an arrangement are not affected by how satisfactory they view such contact.

The final two crosstabulations involved the grouping of podiatric surgeons into ten years age bands. I wondered if age affected podiatric surgeons' attitudes towards collaboration with orthopaedics; would, for instance, the younger podiatric surgeon be more flexible in their views and be more inclined towards adopting a closer relationship with orthopaedics? I crosstabulated, firstly, ages with views on establishing a more formal working relationship with orthopaedics and, secondly, ages with willingness to work under orthopaedic direction.

Both crosstabulations failed to show the presence of a relationship between variables, leading to the conclusion that attitudes among podiatric surgeons towards orthopaedic surgeons are not affected by age.

6.5 Summary of results

Orthopaedic Surgeons

Frequency tables for the results of the orthopaedic surgeon's questionnaires have effectively been summarised in this chapter and I will return to them in the following one. The crosstabulations results, however, are worthy of a summary at this stage.

1) Either having or not having experience of podiatric surgery results does

not appear to influence views on either the provision of podiatry surgery in the NHS or on podiatric surgeons themselves.

2) Attitudes towards the provision of podiatric surgery in the NHS or on podiatric surgeons as a body do not seem to be affected by the number of cases orthopaedic surgeons have encountered.

3) Technical results encountered by orthopaedic surgeons do seem to have some influence on views regarding both NHS provision of podiatric surgery and on podiatric surgeons themselves. The relationship between respondents' experience of technical results and attitudes is one of moderate strength.

4) Perceived levels of patient satisfaction following podiatric surgery have some relationship to attitudes among orthopaedic surgeons regarding both the provision of podiatric surgery within the NHS and to podiatric surgeons as a discipline. This relationship is less strong than that between attitudes and the assessment of technical results of podiatric surgery.

To conclude, although, there is some relationship between both technical results of surgery and perceived levels of patient satisfaction with surgery, the results of crosstabulations fail to fully account for attitudes amongst orthopaedic surgeons towards podiatric surgery.

Podiatric Surgeons

Once again, as frequencies have been summarised already, they will be considered further in the next chapter. With regard to crosstabulations:

1) Whether or not a podiatric surgeon enjoys a satisfactory relationship with orthopaedic surgeons does not relate to how much surgery they

undertake.

2) The views of the podiatric surgeon on the prospect of working under the direction of an orthopaedic surgeon only modestly relate to how much satisfaction they have derived from contact with orthopaedic surgeons.

3) Attitudes among podiatric surgeons regarding improving their working relationship with orthopaedic surgeons, or the prospect of working under their direction, are not related to the age of the podiatric surgeon.

Chapter 7
Podiatric Surgery? – Yes, No, and Maybe

7.1 Discussion of results

Within this discussion I quote extensively from comments made in the returned questionnaires and in personal interviews. All quotes are made verbatim including grammatical inaccuracies. If the quotation comes from a questionnaire it is credited to a Respondent, and if resulting from an interview it is credited to an Interviewee.

7.2 Profiles

The typical orthopaedic surgeon shares the same profile as the typical podiatric surgeon; both are male, aged between 40 and 50, and are likely to live in the south-east. Willis (1994) describes the typical medical professional as upper-middle class, male, and white, and believes that class and gender are important influences in the division of labour in health-care. He argues that the medical profession has found it easier to subordinate occupations which are traditionally staffed by females such as nursing and radiography and less easy in the case of male-dominated occupations such as chiropractic and optometry; in the latter case the medical profession has settled for limitation rather than subordination. A patriarchal division of labour creates, for instance, the doctor-nurse-patient relationship, and this, then, is a reflection of the men-women-children power relations to be found within the family (Willis, 1994). If one subscribes to Willis' view, it seems likely that domination of podiatric surgery by orthopaedic surgeons has proved difficult. Both professions have predominantly male memberships, overwhelmingly so in the case of orthopaedics where only 1.5 per cent are female.

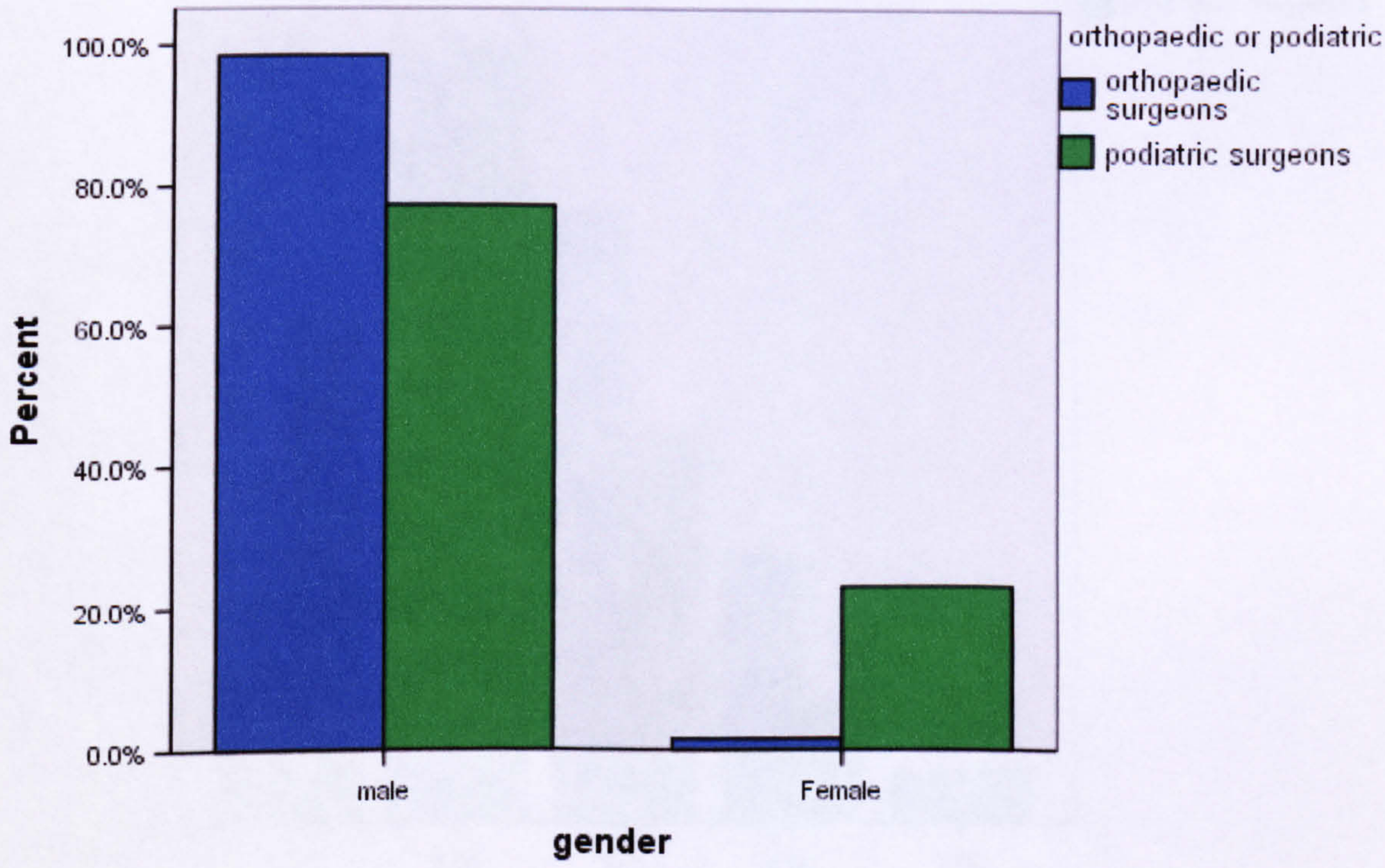

Fig. 3: A comparison of gender in orthopaedic and podiatric surgeons

A comparison of gender differences in the two disciplines can be seen in Figure 3 above. Whilst the proportion of females within the ranks of podiatric surgeons (23 per cent) is higher than that within orthopaedic surgery, podiatric surgery remains strongly male-dominated. If the gender issue does have a significant effect on attempts by one

occupation to subordinate another, it would not have found utility in the orthopaedic - podiatric dispute.

Figure 4, which follows, shows the ages of both orthopaedic and podiatric surgeons within ten-year bands.

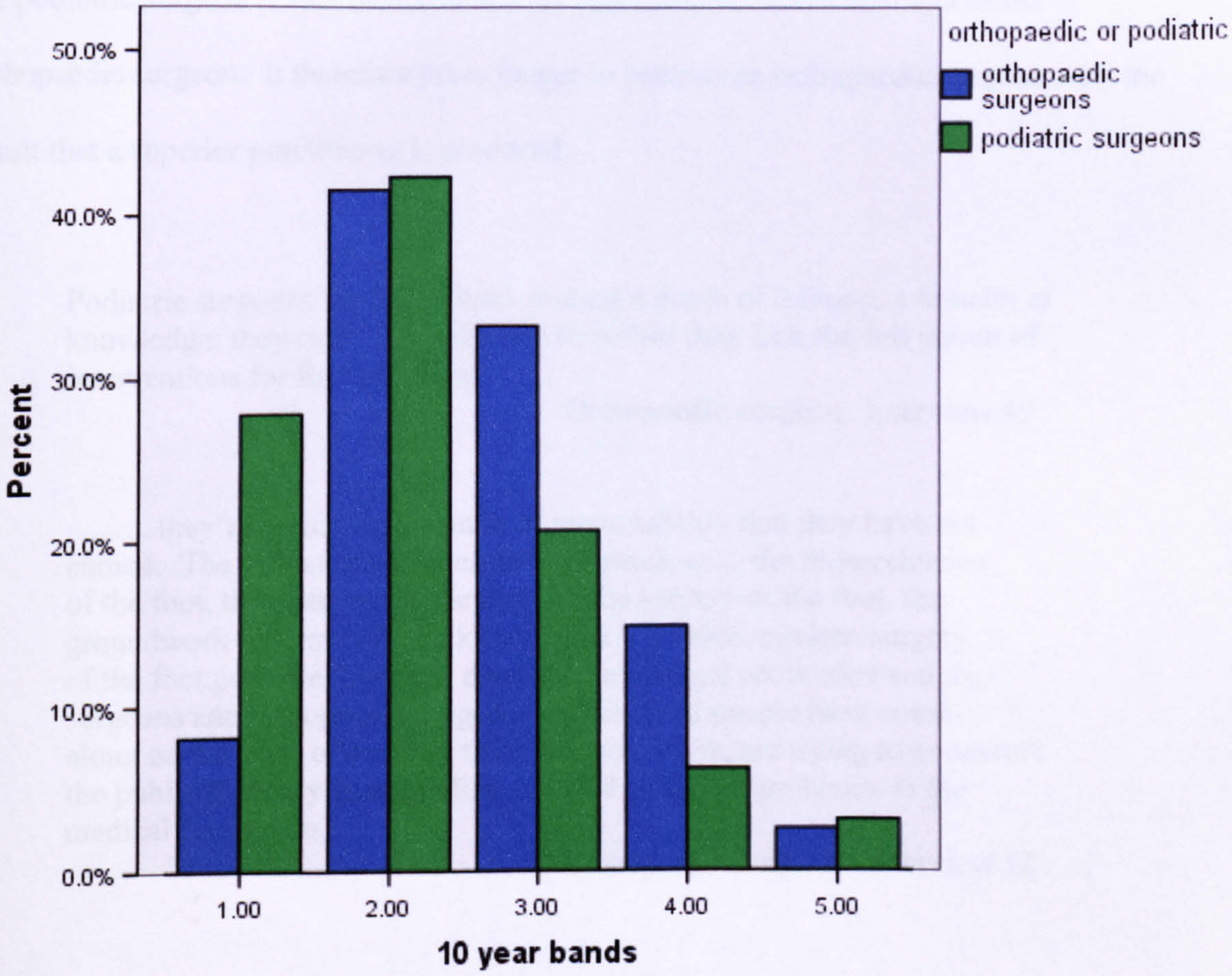

Fig. 4 Ages of orthopaedic and podiatric surgeons

1.0 = 30-39 years
2.0 = 40-49 years
3.0 = 50-59 years
4.0 = 60-69 years
5.0 = 70+ years

The highest proportion of both disciplines is found in the 40-49 band. In terms of relative distribution amongst age bands the two professions show a similar pattern. One notable

difference lies in the 30-39 age range; in this band less than 10 per cent of orthopaedic surgeons are to be found whilst almost 30 per cent of podiatric surgeons are represented here. As the following extracts from interviews suggest, orthopaedic surgeons might argue that this is indicative of the inferior quality of the podiatric surgeon, that is, the training of the podiatric surgeon is less intensive and far less comprehensive than that of the orthopaedic surgeon. It therefore takes longer to become an orthopaedic surgeon with the result that a superior practitioner is produced.

> Podiatric surgeons are individuals lacking a depth of training, a breadth of knowledge; they can't prescribe and therefore they lack the full gamut of interventions for foot problems
>
> Orthopaedic surgeon, Interview 49

> ..... they're assuming a mantle of respectability that they have not earned. The groundwork in terms of research as to the biomechanics of the foot, the anatomy of the foot, all the surgery of the foot, the groundwork in terms of, you know, what it's made, modern surgery of the foot possible, has been done by the medical profession and the surgeons and orthopaedic surgeons. These paid people have come along on the back of our coat tails and, you know, are trying to hoodwink the public that they're as qualified to deal with foot problems as the medical profession
>
> Orthopaedic surgeon, Interview 12

In fact, this statistic that 30 per cent of podiatric surgeons are in their 30s is misleading. I researched Fellows of the BOA who all have consultant status, and their career pathway within the NHS means that an orthopaedic surgeon is more likely to achieve consultant status in his 40s than in his 30s. In contrast, consultant posts for podiatric surgeons in the NHS are relatively few in number; consequently the majority of practising podiatric surgeons are employed at grades below that of a consultant or may even work independently outside the NHS. The lack of a definite and traditional career pathway for

the podiatrist from basic training to full surgical qualifications means that there is no formally stipulated duration of training. Whilst the average length of such training for podiatrists is undoubtedly shorter than that for orthopaedic surgeons, it is nevertheless longer than most orthopaedic surgeons would imagine judging by the lack of knowledge regarding podiatric surgery training exhibited in interviews (see also the findings of Borthwick and Dowd, 2004).

> I think that the basic barriers are that we don't know much about the training programme they go through as podiatrists themselves.
>
> Orthopaedic surgeon, Interview 4

> And a lack of knowledge of the type of training they do, who is eligible to do podiatry, what sort of activities do they do afterwards, what is the scope of their activities be it non-surgical and surgical, and what is their specific training and how long do they train for, under what sort of supervision and the auspices of which sort of Department or College or whatever, all that sort of thing.
>
> Orthopaedic surgeon, Interview 42

Before leaving the subject of age, it is interesting to note that Figure 4, in a sense, captures the complete historical profile of podiatric surgery in the UK. All age groups involved in the development of the discipline in this country are represented here. Those members in the 70 plus age bracket represent the pioneers of British podiatric surgery, that is, those who were at the forefront of learning surgical techniques either in America or from their import into this country in the 1970s. Moving from right to left along the graph, numbers of members increase which reflects the gradual establishment of the discipline. Numbers peak in the 40-49 age group which represents the profession at its strongest level with a high level of practitioners having graduated through the training programme. The lower

but healthy amount within the 30-39 age range involves the up and coming members who represent the future of the profession.

With regard to geography, the highest numbers of both orthopaedic and podiatric surgeons are found in the south-east including London. In this instance numbers are more meaningful than percentages because, with the aid of Figure 5, one can appreciate the overwhelming numerical superiority of orthopaedic over podiatric surgeons.

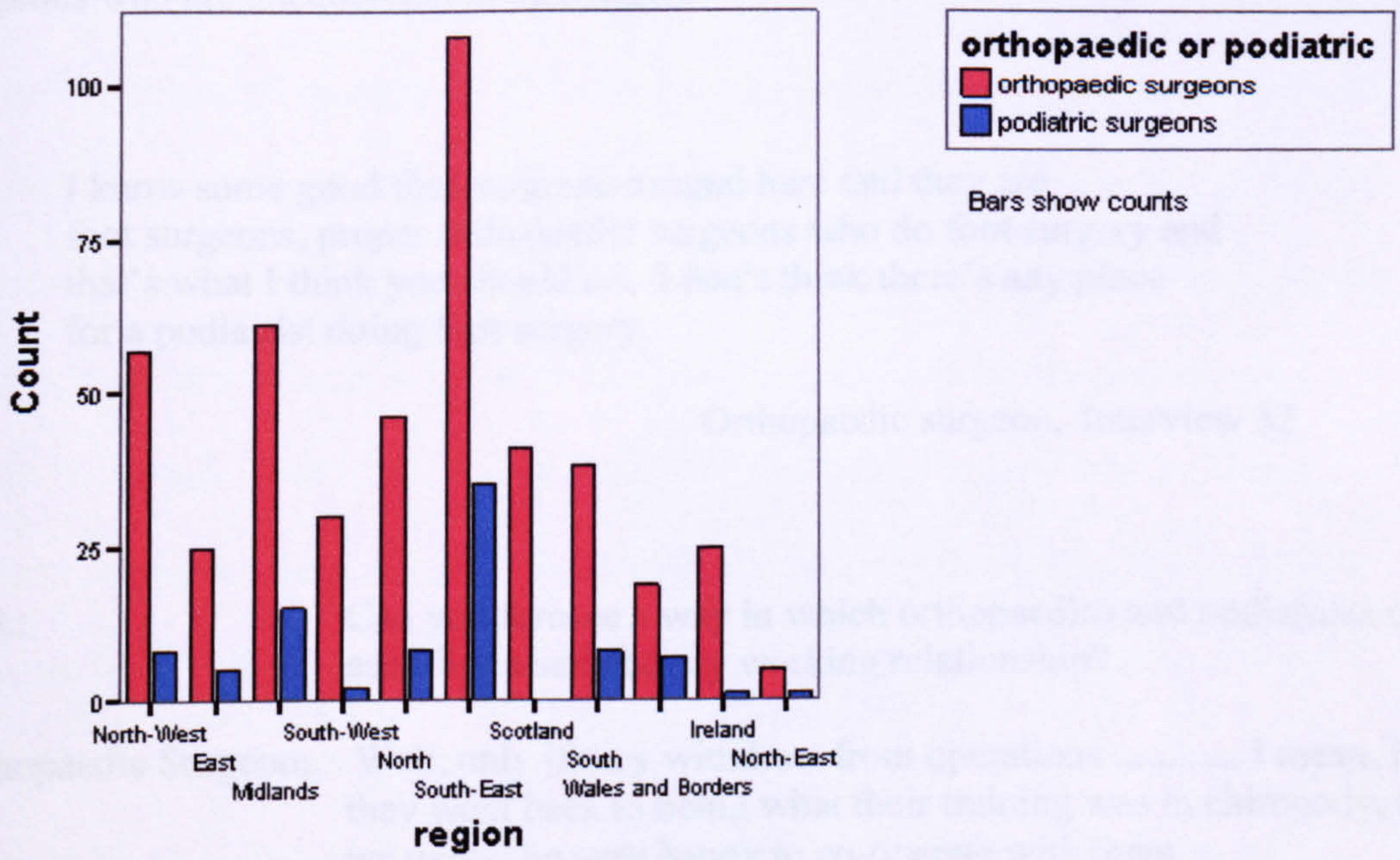

Fig. 5: Geographical distribution of orthopaedic and podiatric surgeons

In most areas podiatric surgeons are heavily outnumbered which could be either beneficial or problematic for them. With a favourable attitude from local orthopaedic surgeons there could be opportunities for podiatric surgeons to establish an effective liaison with ensuing benefits regarding development of practice. In contrast, if local orthopaedics are anti-

podiatric surgery, sheer weight of numbers would represent a formidable opposition towards expansion of podiatric surgical activities.

7.3 The orthopaedic-podiatric relationship

Is there significant resistance to podiatric surgery by orthopaedic surgeons? The simple answer to this is yes, there is! However, there is a spectrum of attitudes regarding podiatric surgery amongst orthopaedic surgeons. At one end of the spectrum lie those surgeons who are unequivocal in their views:

> I know some good foot surgeons around here and they are foot surgeons, proper orthopaedic surgeons who do foot surgery and that's what I think you should do. I don't think there's any place for a podiatrist doing foot surgery.
>
> Orthopaedic surgeon, Interview 32

R.G.: Can you foresee a way in which orthopaedics and podiatrists could establish a satisfactory working relationship?

Orthopaedic Surgeon: Well, only if they withdraw from operations ..... I mean, if they went back to being what their training was in chiropody, then we would be very happy to co-operate with them.

R.G.: Would you agree that, given the present circumstances, that is unlikely to happen?

Orthopaedic Surgeon: I think it's unlikely, I think it's a disaster.

Orthopaedic surgeon, Interview 1

These sentiments regarding podiatrists undertaking surgery reinforce views demonstrated by the frequency tables of the questionnaire results. When asked whether podiatric surgeons should practise when they are not medically qualified, the majority (46 per cent)

of orthopaedic surgeons felt they should not and only 23 per of respondents considered them suitably trained and qualified for the work they undertake.

Orthopaedic surgeons do not see podiatric surgery as a method of improving health-care generally. When asked if costs of providing more podiatric surgery in the NHS would be better spent on 'other aspects of health-care', a large majority of 66 per cent felt they would. Perhaps, though, this question was rather too all-encompassing in using the term 'other aspects of health-care'. The most ardent supporter of podiatric surgery might be hard-pressed to advocate expenditure on a new podiatric surgery unit when the alternative was to provide funds for sorely-needed advanced coronary care! Possibly the most surprising aspect of the answers to this question was the 12 per cent who disagreed that costs would be better spent elsewhere. This is an indication of the other end of the spectrum where orthopaedic surgeons can be quite supportive of podiatric surgery. Before discussing that aspect, though, it is necessary to further consider the issue of opposition. Firstly it should be noted that half of the podiatric surgeons have experienced satisfactory contact with orthopaedic surgeons. Of the remainder, a fairly large 32 per cent are unsure whether to classify their encounters with orthopaedic surgeons as satisfactory or unsatisfactory. The 17 per cent who report unsatisfactory contact describe this under a range of headings. Over 42 per cent of these respondents have met with an unwillingness by orthopaedic surgeons to interact with them. More illuminating than statistics are the comments provided by respondents:

> I introduced myself and was then totally ignored. As I normally have a good working relationship with other people, I think it was the typical podiatric/orthopaedic relationship.
>
> Podiatric surgeon, Respondent 15

Obstructive, obnoxious + rude – but only 1 of a small team – will not even

acknowledge my existence, be in the same room as me!

Podiatric surgeon, Respondent 7

With one exception* (* now retired – one of 2 local 'Foot and ankle' orthopods), a reluctance to have dialogue with me personally or my (Primary Care) Trust despite our ability and willingness to assist with their orthopaedic demand/w/l (waiting list) problems which are considerable.

Podiatric surgeon, Respondent 80

This refusal to interact has led to a situation very accurately described by Freidson (1970). When practitioners refuse to enter into referrals or collaborative relationships with those of whom they do not approve, this amounts to a 'boycott'. However, this 'boycott' does not usually contain those persons' behaviour. Instead they are forced to operate in an area outside the observation and influence of those imposing the 'boycott'. As a result, marked differences between standards of practice and techniques employed are likely to evolve. Opportunities for each group to understand the actions of the other become limited and, without ties between the groups, there is little chance of any leverage being used to influence change in standards or behaviour. Although Freidson was describing the situation where a rift occurs within one profession, while in the current study we are discussing two separate professions, there is nevertheless obvious application of the principles described.

Differences between orthopaedic and podiatric surgeons did not arise as a result of a schism within one profession but because two different professions collided over a territorial dispute. However, perhaps the differentiation into two opposing factors could have been avoided if, early on, there had been greater willingness to interact. There was the opportunity for podiatric surgeons to bring an innovative approach to foot surgery while orthopaedic had much to offer with their broader and historically greater surgical

experience. The ill-fated COPSS report of the early 1990s was probably the best opportunity to date for both sides to meaningfully interact, if not to actually unite. As I discussed in Chapter 3, allegedly suspect politics and questionable motives proved this was not to be so. The decision of some orthopaedic surgeons not to interact with their local podiatric surgeon has not brought about the demise of their service; podiatric surgery has continued to develop outside of any influence orthopaedic surgeons may have hoped to bring to bear. In those areas where podiatric surgeons report good relations with orthopaedics it is usually because there has been some form of collaboration, a point to which I return later in this chapter.

The next two forms of opposition podiatric surgeons have experienced from orthopaedic surgeons are classed as 'obstruction to services' and 'suspicion/hostility' and are cited in equal numbers by respondents:

> Orthopaedics feel threatened by my existence. They are unsure and unwilling to explore my scope of practice. The idea of my access to G.A.s constitutes more advanced procedures rather than patient choice. They have spoiled a working relationship with anaesthetic dept. by degrading my qualifications and lack of admitting rights. They have written to GPs undermining our service and expertise.
>
> Podiatric surgeon, Respondent 5

The comments above from Respondent 5 cover both these forms of opposition.

Respondent 99 graphically illustrates the hostility component:

> Outright war from one or two very politically motivated individuals. Very unprofessional conduct from them. Public denigration of podiatric surgery.
>
> Podiatric surgeon, Respondent 99

Respondent 53 describes opposition but shows that suspicion can be a two-way issue:

> Whilst face to face some orthopaedic surgeons may appear reasonable many are two faced and are gathering evidence to use against Podiatric Surgery. I am convinced by the volume and credibility of those who advise me that orthopaedics constantly and consistently undermine and denigrate podiatric surgery.
>
> Podiatric surgeon, Respondent 53

To be viewed by members of a competing profession with suspicion or greeted with hostility is probably not surprising given the situation likely to arise in the scenario outlined by Freidson (1970) earlier, where competing practitioners don't interact. Freidson also offers an explanation which would account for displays of suspicion or hostility from orthopaedic surgeons: there are three components to professionalism, one of which is a belief in the very way a professional should be able to work, that is, with autonomy, etc. Allied to this is a belief that the professional is superior to others who may approach his or her domain. It follows that the professional feels these people are inferior. For him or her to be so committed to professionalism, it is inconceivable that others approaching their domain can be as equally committed and, therefore, by definition, they must be inferior. This leads to the professional regarding the outsiders with suspicion or hostility.

The obstruction to services is an exclusionary tactic and part of a professional strategy to maintain market position (Turner 1995). Freidson (1970) describes a situation where the 'practicing expert' is handicapped in his exercise of authority because he cannot wield the sanctions normally associated with legal authority or even with bureaucratic office. Orthopaedic surgeons would fit this description when faced with opposition from a podiatric surgery service within their Health District. With no legal authority and no recourse to bureaucratic office, NHS managers having introduced the podiatric surgery initiative, orthopaedic surgeons would have no official sanction at

their disposal. An unofficial sanction would therefore be to deny the podiatric surgeon access to facilities such as the use of general anaesthesia, hospital admittance rights (necessary in the case of severe infection), and so on. Freidson (1970) explains that the medical profession's monopolistic practices are likely to involve not only exclusive control over a particular skill but also the capture of the exclusive right of access to goods and services (such as drugs), thereby depriving the 'layman' of the ability to manage their own problems. Although Freidson was talking within a different context the underlying principle is transferable to the current situation; when orthopaedic surgeons no longer had exclusivity with regard to surgical skills the temptation was there to deprive their competitor of accessory services and thus deny them the capacity to function as effectively as possible.

Of the remaining forms of obstruction experienced by podiatric surgeons, three categories were identified in modest numbers. 'Complaints to management/purchasers' is a self-explanatory term and will have arisen in the absence of orthopaedic authority to impose sanctions as described earlier. 'Personally insulting' is a category indicating a form of obstruction/conflict which could happen in any work-place and could be due as much to personality clashes as to interprofessional conflict. The category of 'misinformation to patients' involves such activities as inferring to patients that they have received an inappropriate procedure from a podiatric surgeon. Whilst this is clearly unprofessional it can probably be considered less sinister than the final category, identified by over 18 per cent of those who have had unsatisfactory contact with orthopaedics; this category is 'incitement to litigation'.

> Referral to local orthopaedic dept. with any kind of post operative podiatric surgical complication has always lead to litigation whether justified or not.
>
> Podiatric surgeon, Respondent 53

..... in both litigation cases of my career an orthopaedic specialist incited the patients to litigation.

Podiatric surgeon, Respondent 31

In 2 cases, medical-neg. claims have been suggested by the orthopod.

Podiatric surgeon, Respondent 59

All litigations we have had in this dept. have all been after patients have had an orthopaedic opinion.

Podiatric surgeon, Respondent 57

This particular form of obstruction is surprising in light of the 'litigation culture' to which all health-care professionals are vulnerable. It has been recognised in the health-care arena that the public are ever-ready to bring claims for compensation in almost every situation where there can be debate about treatment or non-treatment provided; in many areas this has even given rise to 'defensive medicine' where treatments/examinations may be carried out not, essentially, because they are necessary for the patient's well-being but because the health-care professional undertaking them can be seen to do so, and thereby protect themselves from any possible claims of negligence. No speciality is more aware of this than orthopaedic surgery so it is significant that some surgeons should choose to use litigation as a weapon against podiatric surgeons. One may speculate that, on meeting a podiatric surgery failure, an individual may have acted out of frustration. Unable to invoke legal protection against the competition posed by podiatric surgery, powerless to seek help from a bureaucratic source, and perhaps seeing podiatric surgeons overcoming obstacles to the use of hospital services, they may have succumbed to the temptation to incite litigation.

Faced with the various forms of opposition described, podiatric surgeons have

employed a range of strategies to combat them. Firstly, over 46 per cent have attempted to improve communication. This may involve writing to local orthopaedic surgeons and suggesting meeting to discuss matters of good practice from audit results, providing talks to orthopaedics and GPs, or attempting to develop joint podiatric/orthopaedic consultation clinics. However, several respondents commented that these efforts met with little success:

> With my manager, attended numerous local 'Orthopaedic Home Team' meetings and explained our capability to assist.....in a cost-effective way. Not taken up (I gave up going eventually, waste of time).
>
> Podiatric surgeon, Respondent 80

For over 20 per cent of respondents their strategy was simply to 'maintain professionalism' in the face of orthopaedic opposition.

> We have 'fought back' by providing a service where the quality speaks for itself. GPs and managers have consistently supported us. We have resisted attempting to return their 'dirty tricks' and stuck to getting on with our work.
>
> Podiatric surgeon, Respondent 57

Such a stance may maintain or even improve the development of an efficient podiatric surgery service but is not likely to reduce the apparent gulf existing locally between some podiatric and orthopaedic units unless it leads to successful implementation of the next strategy – 'change attitudes through evidence of successful work'. Essentially this involves the use of evidence from audit, suggested earlier as a means of improving communication. This is a positive approach but, as I discuss later in this chapter, the difficulty lies in bringing this to the attention of orthopaedics. A common theme in the interviews with orthopaedic surgeons was that they needed to see evidence of successful podiatric practice. Yet such evidence has long been published and not just in podiatric

journals. Despite this many orthopaedic surgeons appear oblivious to the existence of such information.

Other strategies adopted by podiatric surgeons include, firstly, appealing for help to management. This may bring some short-term relief but stands as much chance of resolving podiatric/orthopaedic conflict as orthopaedic complaints to management about podiatrists. In other words, such a strategy may reduce apparent hostility temporarily but it is unlikely to improve relationships in a lasting way. Secondly, podiatric surgeons have attempted to develop other resources. This generally means attempting to gain access to other facilities such as private hospitals. As a strategy this is not likely to resolve conflict but merely to move it to another location. Thirdly, some podiatric surgeons have opted for direct confrontation. This is a brave approach but destined not to resolve differences. Furthermore, given the sheer superiority of orthopaedic surgeons in terms of numbers, it is unlikely to succeed. Fourthly, offers of assistance to reduce orthopaedic waiting lists were made by one podiatric surgeon. He has yet to receive a reply. Finally, two podiatric surgeons decided to decrease their scope of practice in order not to antagonise the local orthopaedic surgeons, an approach unlikely to be commended by the rank and file of podiatric surgeons.

With the level and nature of resistance towards podiatric surgery from orthopaedic surgeons considered, I now turn to the other end of the spectrum. This is where podiatric surgeons have experienced satisfactory contact with orthopaedic surgeons and where the latter have sometimes proven to be supportive and also shown a willingness to interact.

Positive interaction

Of those podiatric surgeons reporting satisfactory contact with orthopaedic surgeons, most identify the type of interaction as 'generally supportive'. The quotes below show that the level of support can vary and is not always friction-free.

> Orthopod open to new ways of working even though when 1st met had had no contact or knowledge of podiatric surgery – could see the bigger picture. He was able to impress on his more retisent (sic) colleagues the benefits of multidisciplinary working.
>
> Podiatric surgeon, Respondent 54

> One helped me out of difficult complication. Many refer patients for biomechanical problems and treatment. Some obviously feel I should not be doing surgery as I have not got a medical doctorate. No orthopaedic surgeon has ever said to me that I should not be practicing (sic) surgery.
>
> Podiatric surgeon, Respondent 55

> I believe in fact that the relationship on the whole has been satisfactory but without doubt there have been difficulties beset by petty prejudices. The orthopaedic centre which does our MRIs is exemplary. The orthopaedic unit to which I have referred neoplasia of concern act unprejudically and keep me informed over years, not just the immediate period. In general most of the NHS orthopaedic surgeons do act on my referrals. I tend to use them rather than them use me.
>
> Podiatric surgeon, Respondent 56

Two further aspects of satisfactory contact identified in equal numbers by podiatric surgeons were 'integrated service' and 'reciprocal referrals'; closely behind, in terms of numerical identification, was 'joint consultation'. In many ways these three categories are variations on the same theme which could be labelled 'working together'. Reciprocal referrals can occur when there is no formal association between the two disciplines; an integrated service takes this a stage further and represents the situation when both podiatric and orthopaedic services have their own identity within the same clinical directorate but

with clear opportunities for communication. Joint consultation is the ultimate result of close collaboration where both orthopaedic and podiatric practitioners are to be found consulting within the same clinic. The benefits of such relationships are summed up by the respondent below who takes part in joint consultations:

> Case discussion with appreciation of each others' methods and expertise for dealing with the particular case.
>
> Podiatric surgeon, Respondent 36

Other forms of satisfactory contact identified were:-

- referrals – without elaborating on whether these were reciprocal;
- positive communication – where a respondent has indicated that they 'get on well' with local orthopaedic surgeons without elaborating further;
- reciprocal training – essentially where podiatric surgeons give some foot training to orthopaedic registrars in return for involvement in cases of more advanced surgery; this was, however, identified by only two respondents.

Unsurprisingly those podiatric surgeons who have found contact with orthopaedic surgeons satisfactory have seen advantages from the positive relationship. They view the biggest benefit as an altruistic one – improved patient care. Few podiatric surgeons have access to general anaesthesia but, with a working relationship established between podiatric and orthopaedic surgeons, there is an opportunity to offer both day case surgery performed under local anaesthesia and surgery requiring overnight hospital admission when it is performed under general anaesthesia. Additionally, patient care is improved when there is ready access to a second (orthopaedic) opinion and overall the prevailing view is that patients benefit from the provision of a 'seamless' service.

Other advantages are seen as:-

'professional interaction' - We are treated as equal colleagues and exchange information freely

Podiatric surgeon, Respondent 29;

'exchange of ideas and working practices' - An opportunity to build up trust and confidence between both parties. Able to exchange views on our profession and scope of practice

Podiatric surgeon, Respondent 36;

'access to other services' - such as general anaesthesia facilities;

'potential for expansion into other areas of care' - essentially traumatology;

and

'expansion of knowledge'.

Very few podiatric surgeons find disadvantages from closer interprofessional contact. Two respondents did note that in establishing a working relationship orthopaedic surgeons had sought to exert control over the podiatric surgeon; two others reported internal orthopaedic conflict when an orthopaedic surgeon had been admonished by his peers for associating with a podiatric surgeon.

Undoubtedly the most benefits for health-care provision and for practitioners themselves are to be found when a mutually respectful and functional relationship between the two groups has been established. Those cases where this has occurred contrast sharply with those highlighted earlier when the issue of resistance was discussed. Between these polarised positions lie those instances where orthopaedic surgeons, although not steadfast in their opposition towards podiatric surgery, have their reservations concerning its acceptance as a recognised and established form of health-care.

Maybe but only if.....

One of the great benefits of conducting personal interviews was that it gave the interviewee the opportunity to expand on their feelings in a way not afforded by the constraints of the questionnaires. As a result, the interviews revealed that often attitudes among orthopaedic surgeons regarding podiatric surgery are not polarised – there are a lot of 'ifs' and 'buts'. While some orthopaedic surgeons are dogmatic and immovable in their belief that podiatric surgery simply should not exist, virtually none are as assured that podiatric surgery should be encouraged without any reservation. For most of them, there could be a place for the discipline, but only if certain criteria are fulfilled. Whilst some interviewees seemed quite enthusiastic that podiatric surgery could be a beneficial form of health-care, others conveyed the impression that they could grant it approval, conditional on meeting certain criteria, but only reluctantly in the sense that they were resigned to its existence and accepted it is not going to disappear.

Some recognise that podiatric surgery can fulfil a health-care need:

> Now if the pressure were so great that orthopaedic surgery cannot cope with problems regarding the foot, not everyone I mean, but many cases do get relegated, bunions for example do get relegated in terms of urgency, then I don't think orthopaedic surgery can complain much about something which they can't cope with themselves is taken up with someone who can.
>
> Orthopaedic surgeon, Interview 5

Others are analytical about the types of benefit to be gained. Orthopaedic waiting lists have benefited:

> There were gains because our waiting lists decreased as she was able to deal with most of the forefoot surgery. Since she left we have had problems in replacing her and the Trust Board have had mixed views because it's not a traditional type of appointment.
>
> Orthopaedic surgeon, Interview 9

Orthopaedic surgeons could benefit generally:

> But it would be adding, you see, sort of in a cost effective way, it would be adding more physicians with surgical skills to that available to carry out foot surgery which we're grossly lacking in orthopaedic surgeons at the moment and this would certainly help the rest of us concentrate on other things.
>
> Orthopaedic surgeon, Interview 8

Podiatric surgery is recognised as being cost-effective:

> ..... it would be much more cost-effective to have a podiatrist who has a, perhaps, a lesser training, a training which is not so lengthy and not so costly as orthopaedic surgeons, there would be certain, there would be greater cost benefits .....
>
> Orthopaedic surgeon, Interview 8

Aside from these testimonials there are certain concerns about the direction podiatric surgery might take. One frequently voiced concern was about the podiatric surgeon's scope of practice:

> ..... then the following year they'll be wanting to do the mid foot joint, the following year they'll be wanting to do the ankle joint and then they'll be wanting to do procedures in the lower limb which would be totally inappropriate. And it is this view that the Podiatrist may operate anywhere he wishes to at his own volition which I think is the problem bedevilling this particular arrangement ..... And if you said Podiatrists are doing forefoot surgery because that is what is required of them ..... then I think most people would live with that.
>
> Orthopaedic surgeon, Interview 38

Such worries about podiatric surgeons expanding into unlimited anatomical areas are unfounded because, certainly at the current time, podiatric surgeons are restricted to surgery at mid-tibia level, especially for purposes of insurance cover. Nevertheless, these misconceptions are a significant concern for many orthopaedic surgeons fuelled by

anecdotal and erroneous tales emanating from the United States. I will return to this theme later in the chapter.

Another criterion on which approval of podiatric surgery could be conditional relates to podiatric surgeons standing independently and not becoming reliant on orthopaedic surgeons to deal with post-operative complications. This has traditionally proven a problem for podiatric surgeons, very few of whom have hospital admittance rights. If a post-operative complication arises, the most common of which is infection, the patient may need hospital admission and, at least overnight, monitoring and possible further surgery to an infected area. Without the necessary access facilities available to podiatric surgeons, the usual route for these patients is admittance to hospital under orthopaedic care with the result that it is orthopaedic surgeons who directly deal with the complication. There are, then, some who hold the opinion that, if podiatric surgery is to be accepted, it is the podiatric surgeon who should be totally responsible for resolving the problem of complications without recourse to orthopaedic assistance:

> ..... the key thing would be accountability and podiatric surgeons would need to stand or fall by their results. And, if they were achieving good results and the Trusts' clinical results departments didn't feel that their results were any worse than orthopaedic surgeons that do this particular type of surgery, then I don't think, you know I think they should be allowed to stand alone, I'm not sure. The problem about supervision of surgery is that it's one way in which responsibility can be shared or accountability can be shared. I think podiatric surgeons that are dealing with a form of podiatric surgery, they should have all the exposure to all the consequences of full surgical results.
>
> Orthopaedic surgeon, Interview 2

Many advocate that podiatric surgeons should become integrated into a multi-disciplinary team and should not work as an independent discipline:

> Anything which can do something for these people (patients with

> foot problems), anything that can be done to make their life easier, the better. I think on the whole I favour a sort of pro-leader or multi-disciplinary sort of approach that's all I would say. I don't want people going down little blind alleys of their own, that's a backward move.
>
> Orthopaedic surgeon, Interview 17

Such integration could even lead to podiatric surgeons training orthopaedic surgeons:

> ..... I think it's potentially a very valuable situation for everybody. I mean the only potential disadvantage is in training, for all branches really but I think that's something that can be got around. There's no reason why a podiatrist can't teach surgeons some of the more simple foot operations.
>
> Orthopaedic surgeon, Interview 24

Of course the formation of any multi-disciplinary team begs the question, who will lead it? Orthopaedic surgeons are in no doubt about this – the leader will come from orthopaedics. This symbolises the most frequently occurring theme of the personal interviews – control.

> I think it would be much safer if podiatrists are going to be performing surgery for it to be in a hospital environment with maybe the referrals coming through or via the Orthopaedic Department in some way. That way we have the opportunity to work together and if necessary learn from each other. The most dangerous scenario is that podiatric surgery is going on in the District out of our control.
>
> Orthopaedic surgeon, Interview 46

> It's a question of ignorance really in my case. I know very little about the speciality. I would have no objection if they were properly trained and I think under an overall supervision of a fully trained medical person. I imagine I mean an orthopaedic surgeon.
>
> Orthopaedic surgeon, Interview 25

> Well I think it is the manner in which surgery or the manner in which the podiatrists wish surgery to be done. If you say right, well, I am very happy to have a podiatrist working under my care in my hospital, I am the Consultant, he is my podiatrist, he does these operations for me, not

a problem.

Orthopaedic surgeon, Interview 38

So, although many orthopaedic surgeons are amenable to the concept of podiatric surgery, more often than not this means having it organised and conducted on their terms. Not every orthopaedic surgeon insists on orthopaedic control, there are some who are happy to countenance interaction on an equal footing. However, these tend to be very much in the minority and the issue of control is paramount for many. I return to this issue later in the chapter.

To summarise, there is a vast array of opinions regarding podiatric surgery to be found among orthopaedic surgeons. Some practitioners are supportive of the idea of podiatric surgery becoming a 'mainline' NHS service and, indeed, have given practical support in various forms. However, I cannot agree with Borthwick and Dowd (2004:37) who found 'an acceptance of podiatric surgery as a stable feature of NHS healthcare' among orthopaedic surgeons. Many orthopaedic surgeons will only consider podiatric surgery acceptable if it is implemented and controlled in a manner they consider to be appropriate, and even then there are those who would only do so reluctantly. There is also a significant number who remain anti-podiatric surgery, some of whom are totally intractable in their outlook. From those who are unwilling or reluctant to embrace the concept of podiatric surgery has come a significant amount of resistance or opposition towards podiatric surgeons. I now turn to the question of why those practitioners have adopted such a stance.

Why is there resistance?

The crosstabulation results which were summarised at the end of the previous chapter offer little explanation as to why some orthopaedic surgeons are resistant to podiatric surgery. Without the benefit of these results it would have been reasonable to assume that attitudes would be affected by exposure to the results of podiatric surgery. This is not necessarily so, attitudes do not appear related to whether practitioners have or have not encountered podiatric surgery results or to how much exposure they have received.

Quality of surgery results does seem to have some effect on attitudes. Practitioners' opinions on the provision of podiatric surgery and on podiatric surgeons relate somewhat to how they regard results from a practical point of view; the more unsatisfactory they consider results the more likely they are to hold anti-podiatry views. This is illustrated when technical results are crosstabulated with views on whether increasing podiatric surgery in the NHS would result in an increased caseload for orthopaedic surgeons. Those who found technical results mainly satisfactory felt that the caseload would not increase, those who considered results to be neither satisfactory nor unsatisfactory were unsure, whilst those who found results mostly unsatisfactory believed the caseload would increase.

The perception of patient satisfaction following podiatric surgery affects attitudes in the same way, that is, those finding low levels of patient satisfaction are more likely to be opposed to podiatric surgery than those who found higher levels of patient satisfaction. However, one should be wary of reading too much into the assessment of technical results and patient satisfaction. Abbott (1988:137) comments "Since treatment success or failure critically affects the outcomes of interprofessional competition, the power to define success is peculiarly important" and "These incumbent powers to define a problem, to measure its treatment, and to escape comparison are preliminary weapons of professional force". The possibility of a bias in assessing results must therefore be considered; consequently, one

should ask, did surgical results influence negative attitudes towards podiatric surgery or were these negative attitudes ever present and influence the analysis of surgical results? Whatever the answer to this question, the fact remains that the strengths of the two crosstabulations mentioned were only of mild to moderate strength and cannot totally account for attitudes amongst surgeons who have experience of podiatric surgery results. Furthermore, what of those who have no such experience? What explains their attitudes toward podiatric surgery? As the benefit of the questionnaire results lies mainly in gauging levels of opposition, and crosstabulations fail to provide full answers, I turn now to the information collected from the personal interviews to address these questions. Saks (1995) examined the relationship between acupuncture and the medical profession and I referred extensively to his work earlier. I now return to his format in an attempt to explain the reasons for orthopaedic opposition to podiatric surgery.

Lack of diffusion of knowledge

In my earlier use of Saks' format I suggested that a lack of knowledge of podiatric surgical techniques was unlikely to be a factor in resistant attitudes but ignorance of the podiatric scope of practice possibly could be. There is widespread misconception about this scope of practice. As I discussed in the previous chapter, 80 per cent of orthopaedic surgeons have an incorrect understanding of the anatomical limits of the podiatric surgeon's field. This lack of understanding, it seems, has been exacerbated by the orthopaedic version of 'Chinese Whispers':

> She had a very nasty hallux valgus with degenerative change, so they appear to be expanding, but how soon before they go above the ankle?
>
> Orthopaedic surgeon, Interview 7

Actually there is a wariness because of anecdotal tales, mainly from America, about podiatrists replacing knees, I don't know if this is true, and working on the ankle. There is obviously a certain amount of ignorance regarding just what podiatrists do.

Orthopaedic surgeon, Interview 9

With regard to the surgery the podiatric surgeons carry out, bearing on American experience, I'd be apprehensive if the interpretation of gait applied to the foot, wandered very high above the foot. I mean in America they replace the hip which I would be very unhappy about ..... That could be an extreme example, but it does happen in America and certainly in the knee joint with a massive replacement of the knee joint .....

Orthopaedic surgeon, interview 5

American podiatrists do perform surgery on the ankle joint but they do not replace knees or hips. As I explained earlier, British podiatrists confine their surgery to mid-tibia level. In an earlier section I drew attention to orthopaedic surgeons' concerns about podiatrists expanding their scope of practice. When genuine concerns are fuelled by misinformation like the examples above, it is feasible that anti-podiatric feelings may be generated. There is also ignorance about the regulation of podiatrists. Despite one question in the questionnaire stating that podiatrists were regulated by the Council for Professions Supplementary to Medicine (now the Health Professions Council), a lack of appreciation regarding regulation persisted and was clearly evident in the personal interviews:

The podiatrists are self trained, self regulated, unanswerable to orthopaedic surgeons.

Orthopaedic surgeon, Interview 12

..... the public have certainly tarnished their view of doctors and surgeons generally and I think the worry is again, you know, with other people sort of getting in on the act too, are perhaps even less well regulated or whose regulation we understand even less than our own that this, you know, is just going to create yet more problems.

Orthopaedic surgeon, Interview 37

They (the BOA) have declared something on it. I'm not quite sure but

they're not terribly happy about it because it's not regulated.

Orthopaedic surgeon, Interview 36

The least footwork would be done but they have to be regulated. At the moment they are not answerable to anyone and this cannot be.

Orthopaedic surgeon, Interview 50

It is possible that attitudes could be swayed in a modest way by this misconception regarding regulation. However, whilst the prospect of apparently unregulated competition may be alarming, regulation can always be brought about by the establishment of formal channels. As a factor in resistance towards podiatric surgery, ignorance of podiatry regulation is therefore unlikely to feature highly; it is, though, indicative of the widespread lack of knowledge, generally, about the discipline apparent amongst orthopaedic surgeons. This deficit of knowledge extends to the capability of podiatric surgeons, a factor more likely to affect attitudes. This interviewee pays a great compliment to podiatric surgeons but also reveals a distinct ignorance of their capabilities:

> We don't know much about this (podiatric surgery) and they have been developing on their own and then it seems that management and the GPs and the Health Authority they found them to be absolutely wonderful in the sense they create an access to provide quick service outpatient, so in this way they are reducing the number of outpatient referrals and they are seeing them quickly, they are operating on them quickly which is wonderful and I'm not talking, admitting about their ability because until now I don't know.

Orthopaedic surgeon, Interview 13

This lack of knowledge is confirmed by others:

> Because unfortunately, at the moment, they are looked on with some suspicion and, I think, ignorance with regard to what their abilities are.

Orthopaedic surgeon, Interview 8

> I mean, I think that perhaps orthopaedic surgeons need to understand a lot more about, you know, podiatric training, what

> they do, what they're prepared to do, what they see as their role, you know, how far up the foot they are going to go.
>
> Orthopaedic surgeon, Interview 34

Assuming that a lack of knowledge can sometimes create a potential for suspicion or mistrust, there appears ample cause for the development of such emotions in the ignorance of orthopaedic surgeons regarding several aspects of podiatric surgery. In other words, when there is a lack of understanding among orthopaedic surgeons of what podiatric surgery entails, it is likely to be regarded with a certain wariness if not outright concern. One further area in which orthopaedics display a lack of knowledge is in the training which podiatric surgeons undergo and I discuss this later in the chapter under the heading of 'Considerations of Safety'.

Non-effectiveness of the therapy

In the earlier discussion of this topic I reported that audits of podiatric surgery have appeared in several forms of journal. These publications have all been very favourable to podiatric surgery and reports such as those provided by the Department of Health (1994) and the King's Fund (1997) have stressed its merits and advocated its expansion as a method of effective health-care. These reports have largely failed to attract the attention of orthopaedic surgeons. In answer to whether there was a way in which orthopaedic and podiatric surgeons could establish a satisfactory working relationship, Interviewee 3 replied:

> I think that will only happen once these kind of projects are complete and people would see those results and see what sort of proof of the pudding, I think it's foolish to take a prejudiced stance to start with. I think it must be carefully monitored pilot style to see how it fits (a) in terms of skill and outcomes (b) in terms of co-operation and actually being a more efficient service than previously existed before.

Orthopaedic surgeon, Interview 3

Limited knowledge of audit results was displayed by Interviewee 35:

> I don't know who is auditing them, who is looking at them. There was an audit carried out of 24 patients prior to this being started here which was a purely subjective thing. They asked the patients was he a nice man, did you have enough time to ask questions, when you were met at the hospital were the people friendly to you, did they have smiley faces, did it hurt, did you get enough pain-killers, would you have it again? And they were all happy. But there has been no objective assessment of this guy's work at all.
>
> Orthopaedic surgeon, Interview 35

As evidence of the effectiveness of podiatric surgery has failed to reach certain numbers of orthopaedic surgeons it is no wonder that some remain sceptical regarding the benefits the service can provide. Where does the fault lie for this failure? As I mentioned in a previous chapter, many audits have been published in podiatry journals but, equally, many have appeared in literature which has a much broader range of readership. Reports like those from the Department of Health were intended for all disciplines with an interest in foot-care. Podiatric surgeons, as a body, may be criticised for not diffusing knowledge about the positive aspects of their work more widely. Perhaps more attempts to place articles in orthopaedic journals should have been made, though one may speculate how receptive the editors of these journals might be to such an approach. But equally, orthopaedic surgeons, particularly those prepared to question podiatric surgery, are open to criticism for not availing themselves of the information which is readily to be found. Wherever the responsibility lies for not disseminating this information, the fact remains that orthopaedic surgeons are likely to resist an emergent new therapy when they are unconvinced it is effective.

Considerations of safety

When I considered this aspect earlier, I concluded that any concerns about the safety of podiatric surgery were unfounded in the light of the results of audit and the extensive training programme which podiatric surgeons undergo. Of course, this is not to say that these concerns do not exist among orthopaedic surgeons. Ignorance of audit results has now been discussed but a lack of knowledge regarding podiatric surgeons' training was clearly evident in the personal interviews:

> I presume they're put through the full range of orthopaedic procedures and would carry them out as well as myself hopefully, perhaps better, I don't really know. I mean, I'm basically rather ignorant about it. I've never worked with a podiatrist.
>
> Orthopaedic surgeon, Interview 25

> ..... all surgery is an assault, and doctors are trained to assault people for their benefits. Podiatrists are not so trained, and they don't understand some of the ethical issues regarding surgery, nor are they trained in a general medical manner for the consequences of surgery, so they're coming from the wrong angle.
>
> Orthopaedic surgeon, Interview 41

This interviewee seems convinced of his argument but one questions how much knowledge he has of the podiatric surgeon's training. His argument seems to be generalised and is likely to be refuted by podiatric surgeons.

Interviewee 42 admits the gaps in his knowledge:

> Well I don't know because not knowing the training, the scope, the experience, the ability of people, it's very difficult to say what can be achieved, what can't be achieved and how well it's gonna work. Because you may say, well, podiatrists can do ankle surgery but they may not have the expertise or training to do so. They may just be confined to forefoot surgery.
>
> Orthopaedic surgeon, Interview 42

I mentioned earlier in this dissertation that, on conclusion of one interview, I was asked about a podiatric surgeon's training. The interviewee clearly had no conception of what it entailed. I provided an overview and we chatted very amicably for quite some time about the merits of the programme. There is, undoubtedly, very little understanding amongst orthopaedic surgeons of the training a podiatric surgeon undergoes; this lack of knowledge extends to all aspects – entry qualifications, examinations, length of training, the content of training, and so on. It follows that, with this lack of appreciation of the comprehensive nature of the training programme, orthopaedic surgeons will have concerns about the safety of podiatric surgery. Once again, it may be asked – where does the responsibility lie for this lack of understanding? In this case, chiefly, one must look towards podiatrists for disseminating information because it is clearly unreasonable to expect orthopaedic surgeons to research podiatric surgery training, particularly when this is not the sort of thing to be readily found in a monthly journal. The lead must be taken by podiatrists and clearly, from the questionnaire results, we have seen that many have attempted to impress their local orthopaedic surgeons with evidence of effective practice. Whether those orthopaedic surgeons are always receptive to this approach is another matter.

Problems of research

Earlier I noted that podiatric surgery now has its own literature derived from a relatively new but fully established research base. I also suggested that orthopaedic surgeons may be unaware of this because, understandably, contributions to research are essentially published in podiatry publications. It may be that, as I intimated earlier, podiatrists should be more adventurous and attempt to place podiatric articles in orthopaedic journals. Whatever the merits of that argument, concern about podiatric research, or a lack of it, was

not evident in the orthopaedic interviews. It seems, then, almost certain that this is not a factor which encourages resistance amongst orthopaedic surgeons.

Conflicting philosophies of medicine

Previously I made the point that orthopaedic and podiatric approaches to foot surgery do differ. Podiatrists claim a greater understanding of foot function because of an underpinning by the concept of podiatric biomechanics. Orthopaedics, in turn, claim their knowledge of how the foot works is superior. The two sides differ in terminology, underlying beliefs, and techniques which is illustrated in the following interviews with orthopaedic surgeons:

> I do find their language they use, their descriptions they use, their scientific material when they refer their patient it is different from the language we speak and sometimes I see them as a cardiologist in that sense. You know, a cardiologist language of course I don't understand in any sense.
>
> Orthopaedic surgeon, Interview 13

> And that's the worry (different approaches to surgery). You know because some of the things that ..... he's suggested have struck me as being totally illogical. Now whether it's he that's right or I that's right I don't know, and there's no way of proving it I guess. There was certainly a logic in my training.

and

> ..... because they talk a completely different language to what I do. They put an awful lot of fear into people that I can't understand 'cause I can't understand what they're talking about. Now whether that's my fault again or their fault I'm not sure.
>
> Orthopaedic surgeon, Interview 35

> There is one factor which annoys me about them; they feel they can cure backache by giving a heel brace and they dabble outside the field as well.
>
> Orthopaedic surgeon, Interview 7

> I mean if you said to a podiatrist ..... do you think that metatarsus adductus or supinatus in a child will develop into a more prominent deformity in adulthood, he wouldn't know what metatarsus adductus or supinatus (was), not at all, he wouldn't have a clue!
>
> Orthopaedic surgeon, Interview 18

The fact that both disciplines believe their knowledge and understanding of foot function is superior is, firstly, understandable and, secondly, not necessarily an insurmountable barrier to collaboration. Communication and negotiation could lead to co-education with obvious resultant benefits for improved patient-care. However, if both sides remain entrenched in their views and remain convinced of the superiority of their own approach, it is inevitable that orthopaedics will be resistant to the idea that podiatric surgery has merit.

As it stands, both professions have essentially their own knowledge bases and in this respect they can be said to follow different philosophies. The importance of a knowledge base to a profession has previously been noted. I have also explained some key differences in those of the two professions, particularly the importance stressed by podiatric surgeons on podiatric biomechanics. I also observed that there are important similarities between the two especially with regard to general surgical principles and these are what might be described as the technical elements. I use this term because Willis (1994) explains the idea that two related factors form the hegemonic 'cement' by which medical dominance is legitimated. They are, firstly, the ideology of professionalism and, secondly, the ideology of technological determinism. The first involves the 'ideology of expertise'. What this means is that only those with expert knowledge – doctors – are competent to judge on decisions in the health industry; this expert knowledge involves understanding how the body works, what can go wrong with it, and how to correct or

ameliorate that wrong. The second factor involves knowing how to apply technological means to the treatment of disease, that is, it is knowledge about medical science and medical technology. MacDonald (1985) has argued that when occupational skills are in demand, it is of importance if any skill or section of skill can be detached from the main body. If this is possible, then the less skilled or semi-trained may utilise that skill and a stratification of an occupation will result. Effectively this is what happened with the knowledge involved in technical determinism, and podiatric surgery. The podiatrist learned the technical side of surgery – operating theatre etiquette, and safety principles, how to use operating theatre equipment, the application of general surgical techniques, and so on. One half of the hegemonic 'cement' of medical domination was therefore duplicated into the armoury of a competitor. The other half, the 'ideology of expertise' was never wanted in its complete form. Instead, the podiatrist borrowed what was needed – knowledge of health and disease – and substituted his/her own means of addressing abnormalities. If the definition of medical dominance reported by Willis can be accepted, it follows that this usurpation and substitution of knowledge constitutes a serious assault on medical dominance in the area of foot surgery. The podiatric surgeon follows a different philosophy which may be seen by orthopaedic surgeons to challenge some of the principles on which orthopaedic surgery, at least of the foot, is based. Perhaps, then, this contrasting philosophy is viewed by orthopaedic surgeons as a distinct threat to their pre-eminent position in the provision of foot surgery.

The dangers of quackery

I have previously noted Freidson's (1970) view that it is common for a specialist to view any outsider approaching his professional domain with suspicion. In keeping with this

argument, and despite commendations from the Department of Health, there is a view that podiatric surgeons lack ability and are, in effect, 'quacks'.

> We have a saying: 'A good surgeon knows how to operate, a better surgeon knows when to operate, and the best surgeon of all knows when NOT to operate' and these podiatrists don't know when not to operate.
>
> Orthopaedic surgeon, Interview 12

> You know if you're doing a simple straightforward bunion and it goes well then a monkey can do it. But if something goes wrong then you've got to call in other resources than the basic foot surgical training. And I think that's where they fall down.
>
> Orthopaedic surgeon, Interview 48

> ..... there's a case that I had to salvage that this same podiatrist, when he was working elsewhere had done, made a complete and utter cock-up of somebody's first ray. There were wires into the MTP joint, there were screws in very bizarre places and he'd spent about two and a half hours doing this operation, and this woman was no better, if anything worse, and took quite a lot of salvaging.
>
> Orthopaedic surgeon, Interview 35

For some orthopaedic surgeons, then, podiatric surgeons lack capability. There is a strong belief in the superiority of the orthopaedic surgeon and I will discuss this further later in the chapter. However, this uncomplimentary view of podiatric surgeons goes further than simply believing them to be inferior surgeons. An often repeated claim in the interviews was that there had been many surgical disasters associated with podiatrists and the conclusion was consequently drawn that their abilities were so low as to constitute a risk to the public. This contradicts Borthwick and Dowd (2004) who found reluctance amongst orthopaedic surgeons to use surgical mistakes as a means of criticism. However, despite this recurring condemnation there were also a number of contradictory claims:

And I think that the reason that podiatric surgery has done well, to put it in inverted commas, is because it has been carried out by people devoting their time entirely to one small area.

Orthopaedic surgeon, Interview 39

I'm sure you know podiatrists have excellent training and know their limitations.

Orthopaedic surgeon, Interview 23

The chap (podiatric surgeon) that I had ..... was perfectly capable of doing a first metatarsal osteotomy and did a very good fusion, far better than the wretched registrars I would say, you know, and I would be more than happy for him to go and do my fusion if I needed one done.

Orthopaedic surgeon, Interview 48

Whilst some orthopaedic surgeons chose to highlight the podiatric surgery failures they have encountered, others put these cases into context:

Well it's always extremely difficult because the problem is that you have difficulty in analyzing all the data when the podiatric surgeon isn't under your control so you only see the patients that are not happy.

Orthopaedic surgeon, Interview 14

Now I mean I have seen some truly dreadful outcomes from podiatric surgery but my guess would be that I just see the disasters.

Orthopaedic surgeon, Interview 43

One interviewee was actually quite critical of orthopaedic surgery of the foot:

I personally feel that feet is an area that is probably not taught very well. I'm only a relatively recently appointed consultant and felt very unhappy about the level of specialised foot training that was available to me.

Orthopaedic surgeon, Interview 46

Any perceptions that orthopaedic surgeons may have of poor standards of podiatric

surgery will be increased when they become subject to the circulation of misinformation as illustrated in the following extracts from interviews:

> And in those days all my colleagues used to tell me they (podiatric surgeons) will never be happy with forefoot surgery, and they were right and I was wrong. They have spread, particularly in our area, and the guys are operating above the ankle now ..... and giving general anaesthetics. They really have gone, to my mind, well beyond their capabilities and training.
>
> Orthopaedic surgeon, Interview 47

> She said it was absolute agony, she had a fairly major forefoot procedure done under local anaesthetic and she said that she, and she had morphine given and there was no anaesthetist there. I mean, morphine given by a non-medical practitioner!
>
> Orthopaedic surgeon, Interview 29

Some podiatrists do work under general anaesthesia but this is in a hospital environment when the anaesthesia is given by a fully qualified anaesthetist. Podiatrists cannot and do not administer general anaesthesia themselves. With regard to the claim about morphine, this is not likely to be accurate. Not only are podiatrists not allowed to prescribe or administer morphine, it is also a fact that they do not have access to such a substance.

Of course, the results of any type of surgery are more likely to arise in conversation when they are extremely good or extremely bad. Poor results of podiatric surgery will therefore attract their fair share of attention and become widely reported amongst orthopaedic surgeons. When these reports are embellished by probable inaccuracies like the examples above, it is understandable that some may be concerned about 'quackery'.

Increasing such worries is a theme most prevalent in the interviews – surgery conducted by non-medically qualified practitioners. Podiatrists, of course, are not doctors, that is, they do not hold a medical qualification. There has been debate in the past, though, whether or not they have been medically trained and it is fair to say that no consensus has

been reached on this. What constitutes medical training? Does this label depend on who provides the training, the content of the training, or does it depend on the institution within which the training occurs? Traditionally the practical surgical training of a podiatrist occurs under the tuition of a podiatric surgeon and their final practical exams (fellowship exams) are conducted by a non-associated and, therefore, neutral podiatric surgeon. However, the exams which must first be passed to allow one to undertake surgical pupillage (membership exams) follow a course of education on which the majority of instruction comes from medical practitioners – pathologists, radiologists, and so on. These medical specialists not only influence the content of these education courses but also the content of the exams; they play a full part in the execution of the exams by marking papers and in conducting viva voce examinations. This education system is not run under the auspices of a medical school, but when one considers the overall structure of a podiatric surgeon's training it is difficult not to accept it is both comprehensive and exacting. All this, however, may receive little consideration from the many orthopaedic surgeons who, as we have already discussed, may be lacking in knowledge about the training a podiatric surgeon undergoes. What is most significant to them here is that non-medically qualified personnel are performing surgery:

> The specific objection is that podiatric surgeons are not doctors but patients perceive them to be doctors, to be medically qualified and they're not!
>
> Orthopaedic surgeon, Interview 26

> ..... mainly because I think that patients are being treated by people who aren't actually medically qualified, and are often under the impression that the people treating them are medically qualified. So I think there's a problem there of informed consent ....
>
> Orthopaedic surgeon, Interview 29

> I think that surgery should be carried out by surgeons who are medically qualified. I think the difficulty is that you can always spot something if you look at the whole of surgery, that you can basically take someone off the street and train them to do it.
>
> Orthopaedic surgeon, Interview 43

But what of dentists? Despite the recent tendency for them to adopt the title 'Doctor', dentists are not medically qualified. They do, however, perform surgery on the mouth and may be referred to as dental surgeons. The reason why they are accepted by the medical profession, and podiatric surgeons often are not, seems to be that the work of the dentist has never caused a territorial dispute. The medically qualified, quite simply, have never attempted to operate on teeth; as they have never coveted this area of the mouth for work purposes, they have never opposed the development of dentistry in the way that some have opposed podiatric surgery.

Returning to the quotes from interviews above, a related issue appears in the first two examples. It is often claimed that podiatric surgeons are guilty of misrepresentation, that they give patients the impression they are doctors. There is no evidence that such a misrepresentation occurs other than in anecdotal references in some interviews and I have already referred to the 'Chinese Whispers' syndrome apparent in some interviews regarding certain other claims. There is no official record of disciplinary procedures brought against a podiatric surgeon for misrepresentation so these fears appear to be unfounded. With regard to the issue of lack of informed consent, attempts by the BOA to use this as a critical tool against podiatric surgeons were discussed when describing the development of podiatry. The point was made there that consent forms presented to patients prior to undergoing surgery clearly state that their surgery will be performed by a podiatrist. Once again, then, this argument about misrepresentation appears spurious.

The use of titles, or as orthopaedic surgeons claim the misuse of titles, is another frequently occurring theme in the personal interviews and in the questionnaire results. There is objection to use of both the terms 'surgeon' and 'consultant'. There is validity in podiatrists using both these terms which, once again, I discussed in Chapter 3. Nevertheless the use of these titles causes considerable annoyance amongst orthopaedic surgeons.

> Parliament recognises that unless that check mechanism was there you would have all sorts of people being appointed as consultants who would serve the interests of management and other intricate groups, and would not stick up for the patient. But podiatric surgeons are being appointed and calling themselves Consultant Podiatric Surgeons. I've got examples of that.
>
> Orthopaedic surgeon, Interview 12

This interviewee appears to question the validity of podiatric surgeons using the term 'consultant' and also appears to have other concerns on his agenda regarding health-care politics. His opposition to titles, however, is shared by Interviewee 49:

> I don't have a problem with podiatrists as long as they work under a general umbrella incorporating orthopaedic care. I have more problems with them using the term Consultant Podiatric Surgeon.
>
> Orthopaedic surgeon, Interview 49

The root of this annoyance may lie in two beliefs to be found amongst orthopaedic surgeons: their superiority over other health-care workers and the need to control them. I have mentioned the former concept in the previous section and will return to it again later. Essentially, with regard to the use of titles, if one has a profound belief in one's superiority, should one share a title with an inferior worker? Ostensibly the terms 'orthopaedic surgeon' and 'podiatric surgeon' are likely to hold equal status, particularly in

the eyes of the public. If the use of the prefix 'Consultant' elevates one above the level of the 'ordinary' surgeon, this elevation is obviously reduced when those of another 'inferior' discipline also gain the right to use the title. I go on to discuss the concept of control in the next section but the possibility of exerting dominance over other health-care workers is diminished when those workers who are employed on an equal grade, carry as much authority, and enjoy the same benefits.

Before leaving the issue of 'quackery' there is one further consideration which may affect the views of orthopaedic surgeons towards podiatric surgeons. If there is sincere belief that podiatric surgeons are incapable of providing an effective service, the argument follows that they will produce a large amount of surgical failures; this will result in more cases needing the attention of the orthopaedic surgeon and thus extend their already heavy caseload. The frequency tables indicate that 42 per cent of orthopaedic surgeons believe their caseload would become heavier if there was an increase in podiatric surgery in the NHS. The personal interviews gave greater insight into this and also showed that there is a reluctance amongst orthopaedic surgeons to accept responsibility for surgical problems created by podiatric surgeons:

> ..... but there is, I think, disquiet amongst orthopaedic surgeons, not really about taking the work because we've all got plenty of work to do, but I think it's a matter of lack of knowledge about what podiatrists do, what their training is and what happens if something goes wrong, who's going to pick up the pieces?
>
> Orthopaedic surgeon, Interview 8

> For orthopaedics the losses are that we have to spend quite a lot of our time putting right the wrongs caused by podiatric ..... I won't call them surgeons but podiatrists.
>
> Orthopaedic surgeon, Interview 16

In summary, there are several elements to the concept of 'quackery'. For orthopaedic surgeons who intuitively believe their abilities to be superior to those of podiatric surgeons, the latter are perceived as incapable of providing an acceptable level of service. As a result, society is at risk of becoming subject to poor quality foot surgery and orthopaedic surgeons will be required to address the mistakes of the podiatric surgeons. These concerns are increased by the spread of anecdotal tales which may inaccurately report certain activities undertaken by podiatric surgeons. Compounding this unease is disquiet amongst orthopaedic surgeons regarding podiatric surgeons' use of titles which serve to erode any perception of a differential status between the two disciplines.

Professional self-interests

Earlier I reported that Saks (1995) concluded that a threat to professional self-interests (namely wealth and status) was the key reason for the medical profession's resistance to acupuncture. He also noted that this threat chiefly materialised from a challenge to the knowledge on which the profession was based. Before discussing the issue of knowledge, the threat to professional self-interests of a different nature should be considered. This threat, or at least the perceived threat, is one related to the proletarianization and deprofessionalisation theories discussed as one of the challenges to the power of medicine. Annandale (1998, citing Harrison and Pollitt, 1994), notes that physicians' work can be managed in one of two ways: firstly, incorporating physicians into management and, secondly, directly attacking physicians by management. According to orthopaedic surgeons, it is direct attack, and from various sources, that raises concerns for their self-interests:

> that's pretty characteristic of the Health Service these days

that specialists, nurses, physios or doctors, whoever, they get ignored, they're told what to do.

Orthopaedic surgeon, Interview 6

And I'm afraid there's a huge lack of trust between the Trust and the Government and management and everything else. It's all part and parcel of the same problem really.

Orthopaedic surgeon, Interview 11

..... the public don't listen to us anymore. They think that we're self-interested, the spiel about this issue it's seen as self-interest, medical profession protecting its own arse.

and

Politicians took that up, politicians don't want to know, in fact in many political circles there is rejoicing when orthopaedic consultants and the BOA are discomforted and that's sick but that's the truth and everybody knows it.

Orthopaedic surgeon, Interview 12

Orthopaedic surgeons may not have developed a siege mentality but there is certainly a perception that they are vulnerable to attack in various forms. I reported earlier that both the proletarianization and the deprofessionalisation theories have met with criticism but I believe they both have some utility for this study. In terms of the former, McKinlay and Stoeckle talk of an occupation being 'divested of control over certain prerogatives relating to the location, content, and essentiality of task activities' (McKinlay and Stoeckle, 1988:200). Certainly some orthopaedic surgeons agree with this image as they see their autonomy challenged and, perhaps, eroded by enforced changes to their working practices by managers. If the overall situation the orthopaedic surgeon finds himself/herself in does not completely fill McKinlay and Stoeckle's description above of the proletarianized, it does come close to meeting Haug's (1973) definition of the deprofessionalised worker.

Here there is, firstly, a loss of the monopoly of knowledge, secondly, a loss of work autonomy, and, thirdly, a loss of authority over clients.

There has been a loss of the monopoly of knowledge and I expand on this below. If a loss of work autonomy is defined (like Freidson, 1970) as the capacity to determine one's own work content, then autonomy, I contend, remains. The issue here is dominance which Freidson defines as the capacity to determine other occupations' work content. By this definition, with regard to the situation with podiatric surgeons, the dominance of orthopaedic surgeons has been lost.

There is no reason to suppose there has been a loss of authority over clients by orthopaedic surgeons but exclusive control has certainly been wrested away. For those clients who continue to follow the orthopaedic programme of treatment, the authority of the orthopaedic surgeon no doubt remains intact. However, and this is where consumerism plays a part, more and more clients are becoming aware of the possibility of following a different route by considering podiatric surgery. These patients could be lost to orthopaedics so, if limited authority remains, exclusivity does not.

I have argued that, with regard to orthopaedic surgeons, both the proletarianization and, particularly, the deprofessionalisation theories have some applicability, especially where the issue of podiatric surgery is concerned. However, what is most important about these circumstances is not what academic arguments can be made to support the application of these theories but whether or not they create a climate under which orthopaedic surgeons feel threatened. From the evidence of the personal interviews there is a perception that orthopaedic surgeons *are* under a threat which would jeopardise their self-interests; in some respects the challenge posed by podiatric surgeons is directly implicated in this threat and in others it is an additional threat to that posed by other conditions.

Returning to the question of a challenge to the orthopaedic surgery knowledge base, Turner (1995) expands on the importance of specialised knowledge of the professional which

> creates the basis for prestige and social distance between the expert and the client, since the client by definition is excluded from the esoteric knowledge of the professional association.
>
> (Turner 1995:133)

Turner goes on to explain that a barrier has to be created around this knowledge in order to prevent its analysis by external parties which could threaten the social status and prestige it brings:

> the knowledge of the profession has to have a distinctive mystique which suggests that there is a certain professional attitude and competence which cannot be reduced to systematic and routinized knowledge.
>
> (Turner 1995:133)

A recurrent theme in the interviews was the importance and superiority of the orthopaedic surgeon's knowledge over that of the podiatric surgeon.

> Having gone through medical training I think it puts me in very good stead because I understand what diseases are all about, so when you have diabetes or you have a circulatory problem or you have a chest problem you understand what you're talking about.
>
> Orthopaedic surgeon, Interview 32

> I have ..... concerns about them becoming more involved with major surgery because they lack the invasive training and the general backup of a fully trained surgeon.
>
> Orthopaedic surgeon, Interview 45

Many comments on this subject were more vague and did not explain why the

interviewee believed the orthopaedic surgeon was superior:

> ..... their training is not in orthopaedic surgery and it's not in medicine and we shouldn't be allowing people who aren't medically trained to do medical procedures.
>
> Orthopaedic surgeon, Interview 29

> I think that the problem is that podiatrists are not doctors and therefore they cannot understand the totality of a patient's problems, which the foot is only one part.
>
> Orthopaedic surgeon, Interview 1

These last two quotes are typical of many claims which assert that 'only a doctor can be a surgeon'. The basis for these claims was often ill-defined and it seems that, knowingly or unknowingly, interviewees were attempting to uphold the indetermination, the mystique of medical knowledge.

Nettleton (1992) describes disease under the heading of 'spatialization'. This has three configurations: firstly, there is the physical/anatomical basis of disease. Secondly, the psychological, that is, the effects of pain, fear, and so on. Thirdly, there is the social basis, that is, the anatomical area of the body subject to disease (in Nettleton's study, the mouth) must be understood and analysed in its social environment. In interviews, orthopaedic surgeons have claimed that podiatric surgeons lack the capacity to encompass all three of these considerations; their argument is that podiatric surgeons are one-dimensional when dealing with a patient, that is, they are capable of understanding the physical/anatomical basis of disease but fail in the application of the latter two considerations. There was, however, little evidence in the interviews to reinforce these claims; interviewees appeared to be voicing general impressions they held, probably sincere but unsubstantiated. Consciously or not they followed the pattern described by Willis (1994) when discussing

the 'ideology of expertise': as part of this ideology the dominant party will claim the subordinate does not have equal knowledge of the body and only doctors can have full understanding of the patient. In Chapter 3 I reported sentiments expressed in the Faculty of Radiologists statement of 1956:

- doctors are superior to paramedics;
- paramedics lack education and training;
- the medically qualified should direct those who are not;
- only the medically qualified should provide advanced forms of treatment.

Fifty years later these beliefs have not changed. Successive generations have participated in replicating these views which all act to preserve the medical profession's claim to dominance over paramedics. The superiority of the orthopaedic surgeon's knowledge over that of the podiatric surgeon must therefore be continuously asserted if the knowledge acquired by podiatric surgeons is not to threaten the privileges enjoyed by orthopaedic surgeons.

The wealth and status of the orthopaedic surgeon involve an additional factor which does not feature as highly amongst some other medical specialities – private practice. It is fair to say that most private hospitals are primarily dependent on orthopaedic surgery for their existence; this, in turn, indicates that private practice accounts for a significant part of an orthopaedic surgeon's income. If podiatric surgery presents a challenge to orthopaedic domination of the NHS, when it inevitably spills over into the private sector, podiatric surgery also represents a threat to orthopaedic surgeons' incomes. The private practice issue is one, I contend, which orthopaedic surgeons would have been reluctant to highlight either in the questionnaires or in the interviews. There is a connotation of avarice when one refers to private practice and this is a distinct departure from the altruistic ideology which is prominent in some accounts of what constitutes being

a professional, not least the traditional trait and functionalist approaches. As a result private practice rarely appeared as a 'mainline' theme in the interviews but it was to be found fairly prominently, though sometimes almost 'disguised', under other thematic headings:

> We have two in ....., two podiatrists. One who I can't, he does toes and that's it. He does it very well and very good and we're all happy with him ..... The other one is more interested in private practice, does a locum in ....., locum for a consultant and now calls himself a Consultant Podiatric Surgeon.
>
> Orthopaedic surgeon, Interview 47

Interviewee 42 was more direct in describing his concerns:

> At the moment, at the moment I mean, the podiatrists want recognition and perhaps we don't want to give it to them because we don't feel, we don't know, in terms of private practice, they become a threat
>
> and
>
> Because if you are going to say, well, a podiatrist will come to your hospital and work in your hospital environment and that's all he's going to do and not be involved in your private practice, then I think a lot will say yes, there's no problem with that.
>
> Orthopaedic surgeon, Interview 42

A recurring theme in the Podiatric Surgery questionnaires was obstruction to private practice facilities by orthopaedic surgeons:

> Orthopods resent podiatric surgeons in the private sector.
>
> Podiatric surgeon, Respondent 37

> Many times orthopods have attempted to limit my practice, prevent me from gaining private admitting rights .....
>
> Podiatric surgeon, Respondent 31

> At local Private Hospitals, block my access to admitting/theatre privileges by frank opposition of orthopaedic representatives on MACs (Medical Advisory Committees).
>
> Podiatric surgeon, Respondent 80

Present mostly as an underlying theme in this research, the significance of the threat to private practice is worthy of further investigation. It does, however, appear to be another factor in the protection of self-interests.

Orthopaedic surgeons, then, have a market-position both in the NHS and the private sector which needs to be protected from competition. Turner (1995) very accurately describes the strategies that may be employed to enforce this protection. He notes that, to be able to enjoy privileges, a dominant profession must continually exercise control over competitors and that, in health-care, this need is especially evident when paramedical occupations challenge the medical profession. In order to achieve this, a professionalisation process is employed which has three components:-

firstly, the production and maintenance of a body of esoteric knowledge which requires considerable interpretation in its application. In the current situation this has been discussed and, the limitations or failure of the strategy noted. Secondly, the profession will employ exclusionary tactics whereby competing occupations are subordinated or removed from the market. Clearly there is much evidence of attempts to achieve this here. Thirdly, the profession will strive to maintain autonomy at the point of work, that is, resist attempts at deskilling by management which would serve to fragment and routinize the work they undertake with subsequent adverse effects for the relationship between professional and client. Earlier I noted orthopaedics' concerns at the prospect of this loss of autonomy and that the challenge of podiatric surgery occurred against this background.

That such a professionalisation strategy has one overall aim, namely to control the competition in order to protect self-privilege, is confirmed by MacDonald (1985). As a theme, 'control' appeared more often than any other in the analysis of the personal interview transcripts. I now consider what forms of control were advocated by orthopaedic surgeons.

Control

To orthopaedic surgeons control of the practice of podiatric surgery has many features. Some of the interviewees identified specific areas of practice where control was needed but others favoured an all-encompassing approach:

> Well yes, I think one better solution is that they are under the overall control of the Orthopaedic Department and I don't believe it's appropriate for one part of orthopaedics to be hived off to non-orthopaedic departments really.
>
> Orthopaedic surgeon, Interview 15

> I would see the podiatrist in an associated position, sub-serving perhaps in name but, you know, once you got a chap who does what you, what he does well and you know what he does, and you're happy to let him do what he does, then he can do as much as he likes. But it is the position, it's felt it should be under the auspices of a well respected Consultant Orthopaedic Surgeon. And I think that's where most people at senior Orthopaedic Consultant's coming from, that they would see this thing as a possibility but not as an autocratic thing, certainly under the guidance of an orthopaedic surgeon.
>
> Orthopaedic surgeon, Interview 38

Interviewee 15 reveals that he does not recognise podiatric surgery as a separate speciality and perhaps is unaware of the different approaches of the two disciplines; to him it therefore appears obvious that orthopaedics should assume overall control. With Interviewee 38 the belief in the superiority of the orthopaedic surgeon is evident. Whilst

he opposes an autocratic approach from the podiatrist he sees no reason why the orthopaedic surgeon should not occupy a position of authority, with the podiatrist accepting a subservient role. In this scenario, control is comprehensive with the orthopaedic surgeon dictating the content and scope of the podiatric surgeon's work and the latter's subordinate role denoted by the title of 'associate'.

In keeping with the idea that the podiatric surgeon should be answerable to the orthopaedic, Interviewee 12 raises the question of clinical governance:

> Who, who is the clinical governance to these people? The only person who can clinically governance a podiatric surgeon is an orthopaedic surgeon. He's the only one who has superior training and knowledge. In ..... the clinical governance to the podiatric surgeon is under the department of general surgery, and what a general surgeon knows about foot mechanics is dangerous.
>
> Orthopaedic surgeon, Interview 12

This interviewee also believes that the orthopaedic surgeon is superior to the podiatric and possibly also to any other type of surgeon. Clinical governance is a term which is not easily defined; in effect it is an umbrella term which has many components, all of which are designed to ensure a safe and efficient service resulting in improved patient care (Scally and Donaldson, 1998). Of relevance here is that health-care practitioners must be accountable for the safe delivery of health services. So Interviewee 12 is effectively providing the same argument as Interviewee 15, that is, the podiatric surgeon should be accountable to the 'superior' orthopaedic surgeon.

This accountability would mean the establishment of a formal hierarchy within the NHS. For some this should start with orthopaedic surgeons' approval of podiatric appointments:

> I think the only way it can happen is if orthopaedic surgeons are involved

> in the appointment of podiatrists who are then part of whatever there is of a musculoskeletal directorate.
>
> Orthopaedic surgeon, Interview 24

A formal 'chain of command' would thus be established with orthopaedic surgeons dictating which podiatric surgeons would be employed within a Health Service district and what procedures they would be allowed to undertake, with the podiatric surgeons ultimately answerable to them for their results.

Some orthopaedic surgeons would expect less from being able to exert control over podiatric surgeons but see training and supervision as necessary:

> You know I don't think that it is appropriate that they should set up an independent practice without having ever been monitored or supervised by orthopaedic surgeons.
>
> Orthopaedic surgeon, Interview 1

> No I don't have any special objectives as such, provided they are trained and they are under supervision of orthopaedic units, and strict training is undertaken.
>
> Orthopaedic surgeon, Interview 19

Admitting they are prepared to train and supervise podiatrists indicates that some orthopaedic surgeons are willing not only to interact with podiatric surgeons but also that they accept the idea of podiatry surgery as a health-care discipline. However, there is also a certain assumed superiority displayed here; why do they assume that training and supervision is necessary? What of the many forms of evidence of good practice – audits and published articles – to which I have already referred? Such an attitude is likely to alienate podiatric surgeons and not bring a healthy working relationship any closer. Some orthopaedic surgeons subscribe to the view that podiatrists would benefit from orthopaedic

guidance without the need for enduring control; this interviewee opts for temporary supervision:

> And I think that can only be ironed out by more dialogue and co-operation between the various sub-specialities, and again, as a sort of pilot study and perhaps a podiatrist working with an orthopaedic surgeon for a period before they branch out on their own.
>
> Orthopaedic surgeon, Interview 3

For some, benefits of control lie in creating a better standard of practitioner:

> ..... if you have a podiatric surgeon that is doing a procedure on a regular basis year in, year out, to your requirements and specifications and agreements, you may find that you end up with a better end product than having a specialist trainee who rotates round and you get a different one every 6-9 months.
>
> Orthopaedic surgeon, Interview 14

Podiatric surgeons may argue that they are already a satisfactory product, perhaps better than the specialist trainee, and this is because they have *not* been subject to orthopaedic training. Interviewee 14 is clearly receptive to podiatrists performing surgery but he misses an important point – podiatrists are not a sub-speciality of orthopaedics, their approach is very different and they do not wish to become orthopaedic technicians, as will become clear when I consider the views of podiatric surgeons in the next section.

Interviewee 7 views podiatric surgeons as a means of dealing with unwanted tasks:

> Now if that means taking podiatrists under our wings to do some of the more mundane tasks, fine.
>
> Orthopaedic surgeon, Interview 7

Willis (1994) describes this as 'pass the task'. It usually occurs in health-care as a

result of some form of interoccupational conflict; a task once considered to be solely that of the doctor is relinquished to a lower-order occupation when it is deemed mundane. Effectively, Interviewee 7 advocates metaphorically throwing podiatric surgeons some scraps in return for control over them.

Earlier in this account I emphasised the concern present amongst orthopaedic surgeons about a podiatric surgeon's scope of practice. I noted that concerns were increased by some erroneous beliefs but, nevertheless, anxiety existed about expansion into 'inappropriate' areas of practice. Exerting control over the podiatric surgeon would mean that such expansion could be curtailed.

> It must not be allowed to fall totally outside the domain of orthopaedic surgeons. In other words I would expect podiatric surgeons to do limited surgery of the forefoot but they should be, then they should not be totally acting independently if you know what I mean.
>
> Orthopaedic surgeon, Interview 19

With regard to scope of practice:

> There has to be an individual thing and I think you need to ..... see how that works locally and the problem is setting it up and ..... grow other off-shoots of that system. Grow small to big rather than grow big straight away.
>
> Orthopaedic surgeon, Interview 26

This latter interviewee seems receptive to expansion of the podiatric surgeon's scope of practice, but in a gradual way. Others seem more intent on confining it to fairly small areas of the foot and control over podiatric surgeons would create a capacity to do this.

Some orthopaedic surgeons would opt reluctantly for controlling podiatric surgeons because they are resigned that it cannot be eliminated. Control, in these cases, is seen as the 'lesser of two evils':

> If you start getting involved in the training and the regulation

> you're condoning it. I personally would refuse to be involved in that because I don't think there is a role for them and therefore I see no reason to train them how to do orthopaedic surgery ..... But on the other hand if it isn't regulated and controlled one way or another then it's going to get even worse.
>
> Orthopaedic surgeon, Interview 29

The ultimate form of control would involve formal regulation of podiatric surgeons by an official orthopaedic body. Interviewee 50 is in no doubt about the wisdom of this:

> Yes, absolutely. Podiatrists should be regulated by orthopaedics. Their training schools should be shut down and their training and education taken over totally by orthopaedics. That way there would be control and regulation.
>
> Orthopaedic surgeon, Interview 50

In the Orthopaedics Questionnaire respondents were asked if there should be regulation of podiatric surgery by orthopaedics and invited to give reasons for their answer. The frequency tables have shown us that half the respondents believe there should be this regulation. This contradicts Borthwick and Dowd's (2004) findings that orthopaedic surgeons were against podiatrists having any form of affiliation with the BOA or RCS. Thirty three per cent are opposed to orthopaedic regulation but this is not always because they believe existing regulation by the Council for Professions Supplementary to Medicine (now The Health Professions Council) is sufficient; often the reason is because it would indicate orthopaedic approval of a practice they believe should not exist:

> As I strongly disagree with Podiatrists working independently as foot surgeons in the NHS there can be no advantage to BOA regulation.
>
> Orthopaedic surgeon, Respondent 460

Some orthopaedic surgeons believe that an orthopaedic body should not accept the risks involved with taking on this responsibility whilst others feel it would confuse the role of the podiatric surgeon in the eyes of the public. Of those providing reasons for their belief that orthopaedics should regulate podiatric surgery, a majority, 37 per cent, indicate they would like to see it result in a form of control. In the questionnaire, some respondents elaborated on what they meant by 'control' and these sentiments were later repeated in personal interviews; what 'control' meant to many was involvement in hospital appointment of podiatrists, determination of the podiatrist's scope of practice, and the right to govern the practice of podiatric surgery in general.

> Foot surgery should be regulated by Foot Centres – team – led by orthopaedic surgeons.
>
> Orthopaedic surgeon, Respondent 228

> Oversee the appointment of pod surgeons and guarantee they are supervised by foot surgeons.
>
> Orthopaedic surgeon, Respondent 479

> Better control of the conditions for which they are prepared to treat and of the procedures undertaken.
>
> Orthopaedic surgeon, Respondent 390

This desire to regulate podiatric surgery would, of course, necessitate some sort of incorporation or at least affiliation. Such an action would fit with Larkin's (1983) view that the division of labour in health-care has sometimes involved the incorporation of nascent groups. However, if incorporation is not always possible an alternative is to annexe any group that represents a threat.

I have shown that the desire to control the practice of podiatric surgery is clearly evident amongst orthopaedic surgeons. This is a widespread desire which has many

facets. It ranges from wanting to train podiatrists in surgery, to deciding who should be rewarded with hospital appointments and even extends to claiming full authority over podiatric surgeons by acquiring the rights to official regulation. Control, in its various forms, becomes all the more necessary in the absence of an exclusive licence from the state or from society to practise surgery. Freidson (1970) tells us that a profession seeks a licence and mandate from society by persuading its leaders that only their profession has the technical competence and the expertise to provide a safe and efficient service in that particular field to society. If society authorises a licence and mandate, this serves to close off opportunities for competitors of lesser ability. Orthopaedic surgery enjoyed an exclusive mandate for many years. Until the emergence of podiatric surgery in the UK, little more than 30 years ago, the mandate was exclusive because, quite simply, there was no alternative to the service orthopaedic surgery provided. What orthopaedic enjoyed at this time was a de facto monopoly over foot surgery; a true legal monopoly never existed, which in any case is quite rare empirically (MacDonald, 1985). With the gradual emergence of podiatric surgery as a viable alternative, orthopaedic surgery lost that exclusive societal mandate and then found, to the surprise of many, that no legal mandate existed, that is, their Royal Charter did not give them the sole right to practise surgery which they supposed. Larkin (1983) explains that the medical profession has always depended on the support of the state in its control of the evolution of the division of labour. Freidson (1970) agrees in emphasising the importance of state power in any analysis of a profession. Parkin (1971) defined the state as encompassing more than just that faction able to grant legal favours. He also noted that dominant classes in society risked losing their associated privileges if the 'state' ever failed. In essence the state failed the medical profession or, at least, the orthopaedic surgery speciality. It never gave the speciality the

legal protection that some members seemed to believe existed. The protection that it believed it held against the threat of a competitor was only ever a tenuous one, the one granted by society in the absence of alternative services.

To compound this lack of protection, the state further withdrew its previously taken for granted loyalty when economic considerations pointed towards potential benefits from supporting a new competitor. The state, by way of the NHS, found podiatric surgery to be cost-efficient. Encouraging the expansion of podiatric surgery within the NHS on economic grounds also complied with government intentions to reduce what was seen as misuse of the system by hospital consultants. Willis (1994) argues that the state invests power in the medical profession because doctors serve capital interests by providing health measures to keep people working and thereby service the economy. In the case of orthopaedic surgery, then, it seems that the state (by way of the NHS) failed to reinforce this power when podiatric surgery was found to serve capitalism even more effectively by providing treatment more cost effectively.

The speciality of orthopaedic surgery has, therefore, found itself in a largely unprotected position with regard to the competition posed by podiatric surgery. There is no legal recourse to sanctions to contain the expansion of podiatric surgery which has met with widespread approval, in that, surgical results have found favour with NHS bureaucracy and the public alike. Freidson (1970) has argued that, while the granting of a licence and mandate is a state/society issue, the relationship between professional and client is a different matter. Here it is necessary for the professional to maintain a monopoly by closing off alternative avenues available to the client. For orthopaedic surgeons that approach becomes imperative when faced with the loss of state support. To protect their market position orthopaedic surgeons must convince their clientele that the service they provide is superior, indeed that they, themselves, are superior, and deny their

competitor the opportunity to advance their own claims to provide a service. This, I contend, is at the root of the multi-faceted issue of control I have described. Attempts at assuming this control are, for the most part, unplanned and unco-ordinated. It is true that bodies such as the BOA have attempted previously to contain the development of podiatric surgery through such methods as offering unsolicited advice to the Chiropodists Board of the CPSM, and directing arguments about the issues of informed consent and appointment of consultant podiatrists to various agencies, arguments which were duly refuted. There is anecdotal evidence of much discussion and disquiet regarding podiatric surgery in the Councils of the RCS and the BOA. However, a concerted campaign to resist the expansion of podiatric surgery has never materialised, perhaps because there is now awareness that there is no legal foundation for such an approach.

In the absence of any official policy to exert control over podiatric surgery it has been left to individual orthopaedic surgeons to exert influence in any way they consider proper. As I have described, this can vary from inconsequential obstruction on a localised basis to advocating formal incorporation of podiatric surgeons into an official orthopaedic body. In attempting to gain some form of control over podiatric surgery what end result could orthopaedic surgery hope to achieve? Abbott (1988) termed interprofessional power struggles 'jurisdictional disputes' and identified five possible settlements. The first, full and complete jurisdiction, is exemplified by the jurisdiction of law over social matters. Medicine has previously enjoyed such jurisdiction over matters of health. For this type of jurisdiction to occur, the dominant profession will control a subordinate one. Orthopaedic surgeons will not achieve this jurisdiction over foot surgery unless podiatric surgeons completely capitulate to them which seems highly unlikely. Of Abbott's remaining possibilities for settlement, the one that is realistically at least within reach of orthopaedic surgery is a weak one: advisory jurisdiction. This sometimes successfully resolves a

dispute between two professions who already appear to enjoy full jurisdiction in their own fields. In such a settlement one profession seeks 'a legitimate right to interpret, buffer, or partially modify actions another takes within its own full jurisdiction' (Abbott 1988:75). From orthopaedic surgeons' point of view this form of jurisdiction would allow them to influence such issues as training standards and the scope of practice of the podiatric surgeon. The capacity to apply these measures could appease many orthopaedic surgeons and render them less resistant to podiatric surgery. A further type of settlement described by Abbott is one which would represent resolution of the orthopaedic-podiatric dispute but which would not give control to orthopaedics. Abbott terms this 'a settlement by division of labour' and the result is that two groups hold full (shared) jurisdiction in a particular task area. This is, however, very rare. In the next section I consider the attitude of podiatric surgeons towards orthopaedic surgeons and the views expressed. I contend that, short of government legislation (which is highly improbable) the chances of orthopaedic surgeons gaining advisory jurisdiction are remote. Is a shared settlement a stronger possibility?

Beyond discovering the reasons why a profession should resist an emerging new occupation, an intention of this research project was to suggest ways in which the two disciplines in question could develop a more effective working relationship. This would have obvious benefits not just for the disciplines themselves, but for health-care in general. I have no panacea but in the following chapter I seek to summarise methods by which the disciplines could be brought closer together which have been suggested by the participants in this study. I also attempt to identify those factors which must be overcome if any lasting form of conciliation between the two disciplines is to be achieved.

Because the nature of this study revolved around opposition it follows that this aspect of the orthopaedic-podiatric relationship has formed the focus of the discussion up to this point. However, in examining the ways in which this relationship might progress I

lean on the evidence from those orthopaedic practitioners who have appeared receptive to the concept of podiatric surgery. First, though, it should be remembered that there are two sides to any relationship; therefore it is necessary to examine the willingness of podiatric surgeons to enter into a closer working relationship with orthopaedic surgeons.

Podiatric Surgeons

I have examined the nature of contact that podiatric surgeons have experienced with orthopaedic surgeons. Satisfaction and dissatisfaction with that contact have been considered and examples have been provided to illustrate both. It has been established that podiatric surgeons have enjoyed the support and encouragement of orthopaedic surgeons but also been subject to criticism and opposition. How do podiatric surgeons view the future with regard to relations with orthopaedic surgeons? In order to gauge attitudes to this, two questions were asked of podiatric surgeons in the questionnaires: firstly, 'In your opinion, would the establishment of a more formal working relationship between podiatric and orthopaedic surgeons be desirable? (and please explain the reasons for your answer)' and, secondly, 'If the opportunity arose would you consider working under the direction of orthopaedics in a dedicated foot-care team? (and please explain the reasons for your answer)'. In answer to the first question an overwhelming 90 per cent were in favour and only 3 per cent were against such a development. Podiatric surgeons are clearly more open than orthopaedic surgeons regarding the prospect of some form of formal union (compare this with orthopaedic surgeons' views on orthopaedic regulation of podiatric surgery where 50 per cent were in favour of some form of affiliation). This willingness to countenance the establishment of a formal relationship is present despite the opposition that many podiatric surgeons have endured, though the more satisfactory an experience they have enjoyed with orthopaedics the more likely the podiatric surgeon is to view closer union as

favourable (crosstabulation shows a modest strength relationship). Whilst a range of reasons were offered to account for this perspective, two were outstanding. Over 26 per cent believed that such a relationship would increase mutual respect and understanding and more than 23 per cent felt that it would result in improved patient care. Respondent 29 eloquently puts the case for the former:

> The Orthopaedic Surgeon has a far better background in Medical Practice than the Podiatric Surgeon BUT does not have such a broad understanding in conditions of the foot. There is much to be gained from such collaboration provided that the role of each profession is respected.
>
> Podiatric surgeon, Respondent 29

Respondent 94 offers a pragmatic view:

> We can both learn a lot from each other if we could drop some of the egos of some of the members.
>
> Podiatric surgeon, Respondent 94

Respondent 31 succinctly tells us that:

> We all need to work together for the benefit of the patients.
>
> Podiatric surgeon, Respondent 31

Elaboration is provided by Respondent 56:

> It is imperative that funds used for services are not duplicated. Podiatrists hold a professional interest in the foot with consultants often having 10-15 years of experience before their appointment. Orthopaedic surgeons rarely specialise and some have a so called 'special interest'. Working together in collaboration would benefit the public far more because of the many unique skills podiatrists hold. Nothing comes for free and podiatric surgeons

would have to meet some medical standards to ensure greater parity. In the longer term dual qualification might be the best way forward.

Podiatric surgeon, Respondent 56

The two biggest advantages of a closer working relationship are summarised by

Respondent 91:

I'm sure both groups have a lot to offer each other in terms of training and clinical support. More importantly team working will greatly enhance patient care.

Podiatric surgeon, Respondent 91

Despite this positive outlook there are some concerns among the ten per cent who are either unsure or against formal union. Mostly there are fears about loss of autonomy and, with such a loss, limitations on scope of practice:

There is an obvious control issue here. They would obviously prefer us not to exist.

Podiatric surgeon, Respondent 30

It would depend on the nature of the relationship and agreement. The policy of the BOA and BOFS [sic] (British Orthopaedic Foot Surgery Society) (exemplified by 2 or 3 existing posts for Podiatric Surgeons within Orthopaedic teams) is an overtly subservient role including restriction of surgical scope to forefoot surgery (I have had a Job Description on my PC for one such post which is very specific in this respect). Our scope is the foot and the competence and training (fitness for purpose) should largely be determined by our own faculty both as a professional group and as individuals.

Podiatric surgeon, Respondent 80

The latter quote, particularly, shows there are strong reservations about joining with orthopaedics on a formal basis and that some fairly complex politics surround the

whole issue. Clearly, though, there is much enthusiasm amongst podiatric surgeons concerning the prospect of improving their working relationship with orthopaedics. They can see that their own practice is likely to benefit by improvements to their professional knowledge and by broadening their surgical experience. They also feel confident that they have sufficient expertise to reciprocally benefit the orthopaedic surgeons they would interact with. This positive view is commendable in the light of some of the orthopaedic resistance previously encountered which has been highlighted. However, the concerns of the minority are of a substantial nature and cannot be dismissed. As there has been orthopaedic opposition throughout the relatively short history of podiatric surgery, podiatric surgeons are unlikely to now accept a loss of autonomy implied in any formal union when they have successfully resisted such a loss for so long. The issue of autonomy proved to be of paramount importance when respondents answered the second question designed to investigate their attitudes towards improving the podiatric/orthopaedic relationship. Only 10 per cent of podiatric surgeons would consider working under the direction of orthopaedics in a dedicated foot-care team whilst 57 per cent were totally opposed to the idea. Nine per cent were unsure and 24 per cent might consider it if certain criteria were met. As with the previous question, respondents' views are somewhat influenced by the nature of the contact they have experienced with orthopaedic surgeons. Crosstabulation shows a modest strength relationship indicating that the less satisfactory the respondent views the contact the more opposed he/she is likely to be to working under orthopaedic direction. Respondents offered a range of reasons for giving their answers. With two exceptions these were all numerically small and therefore of little significance; five per cent, for example, cited 'best possible patient care' as a reason for agreeing to work under orthopaedic direction while 3 per cent felt it would avoid a sense of isolation. The biggest single category, at 41 per cent, was labelled 'partnership but not subservience'

closely followed by 'against subservience' at 31 per cent. In categorising these themes a difference was noted because 'against subservience' indicated a response suggesting just that, which gave no indication of a willingness to consider the other possibility of 'partnership but not subservience'. Both categories, however, share the belief that autonomy should be preserved.

The following two respondents indicated they might consider working under orthopaedic direction but in both cases their autonomy should be preserved:

> At my age I just might consider this however only if it was indicated that my scope of practice would not be interfered with. With age comes a certain wisdom and experience. Youth can be a bit impatient, there is so much to be learned from General Orthopaedics if approached correctly.
>
> Podiatric surgeon, Respondent 29

The pre-condition set by this veteran practitioner (at the advanced age of 53) is confirmed by Respondent 56 below. As Respondent 29 draws attention to the issue of age, it is worth noting that the age of the podiatric surgeon does not affect his/her view on the benefits of developing a closer relationship with orthopaedics or on working under their direction. Crosstabulations found no relationship between age and attitudes.

> It will always be the case that podiatric surgeons are autonomous in their clinical field; however a department can still work on the basis where a clinician has freedom but acts within an agreed framework ..... A foot surgeon would not nor could not be expected to be relegated to simple digital work as it has been determined our role is the foot and its associated structures.
>
> Podiatric surgeon, Respondent 56

An example of 'against subservience' comes from Respondent 30 who would not work under orthopaedic direction and is quite inflexible in his attitude:

We have never been their Hand Maidens and never will!!!

Podiatric surgeon, Respondent 30

Respondent 31 is against subservience, or even working under direction, but would consider a partnership:

> I would work with orthopaedics but not under the professional direction of anyone from another profession. Would the orthopod work under the direction of a Podiatric Surgeon? We are both experts in our fields and Autonomous (sic) professionals.

Podiatric surgeon, Respondent 31

Respondent 53 is against working under orthopaedic direction and sums up podiatric attitudes towards this issue in a series of points:-

- Contravenes code of conduct
- Development of a (sic) orthopaedic foot technician would ultimately lead to the end of podiatric surgery
- Orthopaedic control maintains medical dominance of allied health professions
- Orthopaedic direction means loss of responsibility and autonomy
- Restriction to practice i.e. distal to the TMT joints
- Orthopaedic control of training and development
- If orthopaedic foot surgery so successful why the development of Podiatric Surgery?
- Evidence base. Helm (and) Ravi article strongly supports Podiatric Surgery over orthopaedic surgery.

Podiatric surgeon, Respondent 53

In conclusion, podiatric surgeons are, for the most part, very enthusiastic about

improving their relationship with orthopaedic surgeons. Despite experience of orthopaedic surgeons' resistance to the progress of podiatric surgery, there is a realisation that further progress will be easier if orthopaedic and podiatric surgeons work together in some form of collaboration, providing reciprocal benefits, than if the disciplines remain isolated from each other. Such isolation will not only continue to foster interprofessional rivalry but it will adversely affect patient care as this can only be maximised if the attributes of both disciplines can be harnessed towards the same end.

Any such collaboration can only occur if it is arranged on a partnership basis. Working under the direction of orthopaedics is not an option for the majority of podiatric surgeons who have fears for their continued autonomy. There are several aspects to this autonomy. Podiatric surgeons see themselves as professionals in their own right who should not be subservient to any other profession. Indeed, they see their surgical expertise of the foot as superior to that of orthopaedic surgeons and hence believe they should not work under their direction. This sentiment also pertains to the argument for surgical training. As the last respondent asked, if orthopaedic surgery is so good why is there podiatric surgery? I have used this argument myself in debate, that is, podiatric surgery only evolved because the general standard of orthopaedic foot surgery created an opportunity for it to do so. If this is the case, why should orthopaedics oversee podiatric surgery training? For the podiatric surgeon, working under the direction of orthopaedics would also mean a restriction on his/her scope of practice. We have already seen, in exploring attitudes amongst orthopaedic surgeons, that there are concerns about podiatric scope of practice. Often these concerns have been fuelled by inaccurate claims particularly from the USA. The net result, however, is that, for many orthopaedic surgeons, the limit for podiatric surgery should be set at the forefoot only. But podiatric surgeons, as

evidenced by the questionnaire responses, will ask why they should accept such a limit when they are currently able to work surgically on the whole of the foot?

Overall, then, while podiatric surgeons have reservations about the merits of orthopaedic surgery, their biggest concern about formal union with orthopaedics concerns autonomy. Essentially, they are unwilling to consider adopting a subservient role in any form of union which would serve to maintain, or even reassert, medical dominance in the field of foot surgery. The views of podiatric surgeons towards collaborative working with orthopaedic surgeons are therefore complex. There remains, however, a willingness to explore the possibilities of developing closer ties.

7.4 Implications

What implications for the two specialities can be drawn from these findings? I return to Abbott's (1988) scheme of jurisdictional settlements and ask which of these would be acceptable to each profession, given that orthopaedic surgeons no longer have full jurisdiction over foot surgery. Firstly, would orthopaedic surgeons be content with advisory jurisdiction? As I suggested earlier this might give them some significant input to podiatric surgery in terms of exerting influence in such matters as training standards and scope of practice. This might represent some form of 'control' which I have shown to be of paramount importance to many within the profession. For podiatric surgeons there could be benefits from such a settlement if it led to the establishment of a closer working relationship; such benefits, for example, might involve increased use of facilities and expansion into other forms of treatment such as traumatology. However, as autonomy is so important to them, this could only occur if they felt that they were not being 'controlled', a situation which, I suggest, would be difficult to achieve. It may be that a

shared jurisdiction would be a more realistic proposition. In such a scenario each side would be answerable only to themselves but this is, effectively, the situation at the moment. Podiatric surgeons are currently totally independent of orthopaedics who remain the most prominent authority in the treatment of foot disorders without exerting influence over the former. This shared jurisdiction could continue but it would not resolve areas of conflict and simply represent a 'stand-off'. For podiatric surgeons this may offer continued autonomy but the danger could be that the speciality would stagnate without the possibility of expansion into other areas of foot care. A more satisfactory result (for podiatric surgeons and perhaps for patient care) would be a shared jurisdiction which also involved sharing working practices, that is, team-working. As noted in Chapter 2 Tousijn (2006) reports that such a concept – 'multi-professionalism'- is growing fast and results from the growth of the knowledge base of other health-care professions and a 'blurring' of traditional inter-professional boundaries. This idea gains support from Broom (2006) who found a willingness to interact amongst biomedical and complimentary and alternative medical (CAM) practitioners working in cancer care. Significantly he noted that the willingness of one 'side' to absorb elements from the 'other' benefited both patient care and professional standing and created a more pluralistic therapeutic environment.

But the implementation of 'multi-professionalism' is not a straightforward process. Even though the concept is a feature of government health policy, it is one thing for the state to emphasise its benefits and to commend 'multi-professionalism' to grass-roots practitioners and quite another to ensure that it is adopted. Broom (2006) reports on attempts by both contending professional parties to adapt their approach to cancer care according to the influence of the 'other', and claims that each sees 'potential legitimacy' in some features of the other. However, he qualifies this by saying that such changes are occurring 'at least rhetorically' and also reports on a 'significant degree of negativity

towards CAM amongst the oncologists' (Broom, 2006:500). The implication is clear – the theory of team-working may not necessarily translate into the practical working environment.

With regard to the relationship between orthopaedic surgeons and podiatric surgeons, we have seen previously that there has been some productive collaboration between the two professions in various parts of the country. One cannot be sure how much state policy on team-working has shaped these initiatives; what is clear, however, is that such policy has not resulted in universal or even wide-spread collaboration. In the next chapter I suggest ways of bringing the two specialities together which might facilitate such a development.

On a broader note, forming either a shared or an advisory jurisdiction could be viewed as a stage in the reconfiguration of medical dominance along the lines proposed by Allsop (2006) and Dent (2006). The latter's description of professionalism as a 'dynamic process' echoes that of Larkin (1983) who talked of occupations' regular manoeuvring for position. The formation, dissolution, and reformation of various forms of jurisdiction between the medical profession and other health-care occupations is, therefore, likely to be an ongoing process. By the same argument, if the health-service reforms of the last two decades are an indicator, all health-care occupations will need to continuously re-negotiate their position with others and with other agents, chiefly the state. In relation to the medical profession, Tousijn (2006) describes the need to form a 'new social contract' with society which would replace the nineteenth century one which is now 'untenable'. Such a contract would need a new medical paradigm, which would require at minimum forming new relationships between different professions and working towards 'multi-professionalism'.

7.5 Auto/biography revisited

It needs to be acknowledged how my involvement in this study as both a researcher and a participant in the process under investigation has shaped the interpretation and analysis of data. My role as a participant has helped considerably in understanding and interpreting the data because I have had recourse to knowledge which another researcher may not have enjoyed, thus concurring with the assertions of Hockey (1993) and Bonner and Tolhurst (2002). Examples of this include an appreciation of the career pathways for a podiatric surgeon which enabled me to place orthopaedic surgeons' views on podiatric surgery training into context, and the certain knowledge I had regarding podiatric surgeons' access to general anaesthesia and morphine which indicated that orthopaedic surgeons held misconceived opinions about this issue.

However, I did enter the study with certain preconceptions as a result of being an 'insider' (Robson, 2002; Breen, 2007). For example, my initial theory was that I would find few examples of co-operation between podiatric and orthopaedic surgeons but this theory had to be revised when a significant level of collaboration emerged and ways by which positive interaction could occur were signposted. I also held something of a stereotypical view of orthopaedic surgeons and assumed I would meet with a certain arrogance and find little evidence of regard for podiatric surgeons' capabilities. I did encounter arrogance and some fairly hostile responses. However, I also met with enthusiasm and generosity, not to mention encouragement for podiatric surgery. As a result, it is fair to say that my attitude and approach to the later personal interviews was different to the earlier ones, albeit that I kept to the same format throughout. From that point I began to have greater confidence that resolution of the conflict between orthopaedic surgeons and podiatric surgeons was possible. It is also true that, up to that time, my 'insider' status had given me an 'illusion of sameness' (Pitman, 2002), that is, an

assumption that most respondents held the same type of views. Such an assumption therefore had to be revised when I discovered a wide spectrum of attitudes ranging from the hostile through to the supportive.

At times I accept that my subjectivity has been exposed. For instance, I defend the use of certain titles by podiatric surgeons and commend them for being receptive towards the idea of collaborating with orthopaedic surgeons when they have been the victims of opposition. On the other hand I have given credit to orthopaedic surgeons where it seems appropriate, for example I have explained quite comprehensively about the support that some have shown to podiatric surgeons and made the point that attempts at collaboration have resulted in the production of an improved service.

In this chapter I have also exercised critical judgement. This may be seen in such areas as where I find fault among orthopaedic surgeons for a lack of knowledge regarding podiatric surgeons, and particularly in my interpretation for the reasons behind obstruction by orthopaedic surgeons. However, I see this as my function as an observer and as a researcher, and also, ultimately, as a commentator. I was fortunate to collect a wealth of data which has provided me with many illustrations for any arguments put forward. The use of such data as supportive evidence should, however, be tempered by Fine's assertion that research involves "carving out pieces of narrative evidence that we select, edit and deploy to border our arguments" (Fine, 1994:22). In other words, in the absence of 'an absolute truth' (Letherby, 2002), my arguments represent my version of reality, that is, they result from how I have interpreted the data. Ultimately, of course, the reader will make his or her interpretation of the data I have presented and arrive at their own conclusion.

Chapter 8
The Way Forward?

8.1 Bringing conciliation?

I have shown that orthopaedic surgeons' responses regarding podiatric surgery fall into three categories. There are some who are receptive to the idea of accepting podiatric surgeons into the NHS and are prepared to work alongside them in productive co-existence. Others are not adamantly against the discipline but would give tacit approval dependent on certain considerations being addressed. The final category involves those surgeons who remain steadfastly opposed to the entire concept of podiatric surgery. It is to the ideas of the first category I now turn in an attempt to identify methods which could be followed in order to overcome the resistance of those who remain in opposition.

That good relations already exist between many podiatric and orthopaedic surgeons is not in doubt. There is evidence to be found in the personal interviews which confirms reports from podiatric surgeons:

> I'm a lower limb surgeon and I recognise the importance of biomechanics and orthotics and podiatric assessment in a variety of conditions, so we already have a decent working relationship.
>
> Orthopaedic surgeon, Interview 2

Earlier we saw that the most productive relationships between podiatric and orthopaedic surgeons were to be found where there was some element of collaboration; this usually involved reciprocal referrals, working within an integrated service or taking part in joint consultations. From the evidence of the personal interviews, it is clear that some orthopaedic surgeons believe that collaboration is the key to not only developing a successful working relationship with podiatric surgeons but also to providing a beneficial and comprehensive service to the public. Firstly, there needs to be a willingness to co-

operate leading to effective communication and this, in turn, will lead to integration and teamwork.

Co-operation

> So I think that the way forward is for mutual co-operation and so that we share our ideas and that I don't see any reason why podiatrists can't be part of a team of surgeons who operate on the foot and ankle.
>
> Orthopaedic surgeon, Interview 12

> I think there's also a slight suspicion that their training is not in accordance with modern orthopaedic understanding, that a lot of perhaps unnecessary or misguided procedures are being done as orthopaedic surgeons see them ..... And I think that can only be ironed out by more dialogue and co-operation between the various sub-specialities.

and

> ..... and there would have to be close co-operation between them, if there wasn't close co-operation I think that would be bad, certainly a matter of personalities would be important I think.
>
> Orthopaedic surgeon, Interview 3

Both interviewees above agree on the need for co-operation but together they also indicate a potential problem. The key word in the first quote is 'mutual'; there must be a willingness to co-operate from both sides if there is to be effective communication. In the last quote, the possible difficulties posed by inflexible personalities were hinted at. Until this point in the study only the resistance of orthopaedic surgeons has been considered but it would be naive to think that podiatric surgeons could not be equally 'at fault' for any impasse in an interprofessional relationship. Earlier a podiatric respondent identified such a problem when he talked of the need to overcome 'the egos of members'. In podiatric circles, orthopaedic surgeons are stereotyped as being arrogant yet, in the eyes of clinical

podiatrists, the same is probably true of podiatric surgeons. Realistically, strong personalities are a potent force in many highly successful professionals. It would be important that an individual entered into communication with the opposing discipline in a true spirit of co-operation if effective communication was to ensue. This is particularly necessary when, as I explain later, there is a belief that it is local and not national negotiations that hold the key to successful collaboration.

Communication

> I would have thought that with communications arising, that people would be prepared to talk to each other and answer to wildly extremes in either camp, I would have thought that there would be some productivity.
>
> Orthopaedic surgeon, Interview 5

> The old, old story, get together, talk about it in a sensible medium, without losing one's temper. Now that, you might think, oh, we're into utopia here.
>
> Orthopaedic surgeon, Interview 7

What should communication involve? I believe 'negotiate' could substitute for 'communicate' in this situation. Communication would not mean simply making contact with the rival group and informing them that one intends to undertake surgery on their doorstep. It would mean taking advantage of an opportunity to correct misconceptions, to educate, to allay fears, and to negotiate towards reaching an acceptance of working practices. I am advocating that these initiatives come from podiatric surgeons. Firstly, orthopaedic surgeons sometimes hold erroneous beliefs about the anatomical areas podiatric surgeons work within and the procedures they undertake; this is exacerbated by mistaken beliefs that podiatrists, for instance, give general anaesthesia and administer

morphine. The podiatric surgeon could correct these impressions and help the orthopaedic surgeon to overcome the lack of knowledge and understanding which appears evident in certain areas. Such matters include the training of a podiatric surgeon, the regulation of a podiatric surgeon, and the potential benefits podiatric surgery can provide not only to the public but to orthopaedic surgery as well. The latter could be facilitated by providing evidence of effectiveness and safety which so many orthopaedic surgeons requested in the interviews, but of which they were completely unaware.

With the benefit of a greater appreciation of podiatric surgery by orthopaedic surgeons, negotiations about working practices within a particular NHS Trust, for example, could follow. Successful negotiations are only likely to result if orthopaedic surgeons accept that podiatric surgeons are autonomous; they are not open to being 'supervised' or to working 'under' an orthopaedic surgeon, in short, they will not be controlled. Negotiations should proceed with collaboration in mind.

> I could only see it working as a team of equals.
>
> Orthopaedic surgeon, Interview 27

> I mean I think we should be working much more as a unit, as a team. And I think like that you begin to offset the problems that have arisen previously.
>
> Orthopaedic surgeon, Interview 24

> I see advantages if it is done in an integrated service. We should have orthopaedics, podiatrists, physios, orthotists, etc.
>
> Orthopaedic surgeon, Interview 10

We have seen previously that the most successful relationships between podiatric and orthopaedic surgeons occur when working within an integrated service and ideally

undertaking joint consultations. I reiterate that this should not involve supervision and, in fact, many orthopaedic surgeons recognise this. As one orthopaedic surgeon commented, supervision is

> an area of considerable difficulty. Podiatric surgeons generally don't want to be supervised like that and nor do orthopaedic surgeons want to take on the responsibility for doing so.
>
> Orthopaedic surgeon, Interview 5

In an earlier section it was seen that some orthopaedic surgeons believed they should not share accountability for podiatric surgical complications. At face value, orthopaedic surgeons have a right not to want to take on such responsibility, yet they have the facilities to deal with certain complications which podiatric surgeons may not have. This would require flexibility in negotiations in order to reach a satisfactory settlement. An integrated service would also offer a solution to another problem highlighted extensively in the interviews, which is a reduction in training opportunities for young orthopaedic surgeons.

> Well, I think the major difficulty is in training and as I say our career registrars are now exposed to almost no, they see the more difficult stuff but they don't get exposed to things which they may be faced with as Consultant Orthopaedic Surgeons.
>
> Orthopaedic surgeon, Interview 6

> ....since it's quite clear that podiatrists couldn't provide all the amount of foot surgery that was necessary in the country. We would have considerable difficulties in training young surgeons to undertake any form of foot surgery.
>
> Orthopaedic surgeon, Interview 11

However, Interviewee 8, who also recognises the problem, offers a solution:

> .....foot surgery is something which is quite common and is the type of operation which can be used for teaching orthopaedic trainees ..... But there's no reason why a podiatrist couldn't train orthopaedic trainees.
>
> Orthopaedic surgeon, Interview 8

Clearly such an arrangement becomes a possibility in an integrated service and would only serve to reinforce a positive collaboration. What form should negotiations take, and from which direction should they come? There are mixed views on this. For some, formal negotiations would not work:

> I can't see any formal, no I really can't. It's like a lot of these things, they evolve rather than suddenly put in place ..... And I would think it's an evolution perhaps rather than a sudden imposition upon the profession.
>
> Orthopaedic surgeon, Interview 25

For this interviewee acceptance of collaboration with a rival discipline cannot be forced on a profession. Acceptance will come gradually over time, if at all. Others believe in a more pro-active role. There is some argument for negotiations to occur at a national level:

> I would have thought that ..... a higher level like the BOA ..... so (from) the governing body, the regulated body levels (comes) a clear framework of an understanding of, you know, what each is about.
>
> Orthopaedic surgeon, Interview 28

The strongest view, though, is that negotiations should occur on a local basis.

I think it has to be discussed locally really because orthopaedic surgeons vary in their views up and down the country but, and the same I presume with podiatrists .....

Orthopaedic surgeon, Interview 23

I think it's just gently and slowly plugging away, working with perceptive people and trying to get a sort of collaborative approach. I don't think this is the sort of thing you can solve by central direction, I really don't, I think that would not work. I think it's very slowly, try and work together and that's really all I can say.

Orthopaedic surgeon, Interview 17

Perhaps this is the correct approach. Those areas which can already demonstrate the existence of healthy interprofessional relationships stand as evidence of what successful local negotiations can achieve. It is hard to imagine that a central dictatorial approach will overcome the deep-seated resentment to be found in some regions and, although local negotiations may ultimately fare no better, they probably stand a better chance of achieving some success.

If this discussion of possible ways of improving the orthopaedic-podiatric relationship has suggested the process should be a simple one – a case of 'joining up the dots' – this was not my intention. Matters concerned are complex and the issue of control is certainly multi-functional. I have attempted to point out that there is a certain amount of goodwill on both sides and, in some quarters, a willingness to explore possibilities for mutual advancement and benefit. There remain, however, some contentious beliefs that are not easy to overcome. Essentially these are beliefs which form part of the ideology of professionalism and, as such, as fairly intractable. I have previously referred to a component of Freidson's concept of professionalism – the professional's belief that, because 'he' is superior, any other who approaches 'his' domain must, by definition, be

inferior. The other two components of this concept are: firstly, a service orientation with all the elements that entails such as the desire to serve others, and so on, and secondly, the 'want' to be a doctor, for the social rewards this brings as much as anything (Freidson, 1970). In its complete form this concept is strong and will continue to persist within the orthopaedic surgery speciality. How then does a supposedly 'inferior' occupation overcome the deep seated 'superiority' of orthopaedic surgeons? Is the following orthopaedic surgeon about to readily negotiate equal working practices with podiatric surgeons?

> And that is the big mistake that is made by everybody in general public, nursing profession, even GPs, sociologists, you all make the same mistake. You think I'm a special person because I wield the knife and I cut people in theatre. I am not! I'm a special person because I have the insight to do the right operation!
>
> Orthopaedic surgeon, Interview 12

Elitism is a barrier to successful negotiations and Hunter (1994) asserts that this is reinforced in the education of the doctor; there is little training in negotiation and team building skills and, as a result, the doctor is more likely to participate in building vertical rather than horizontal relationships.

This belief in superiority extends to the use of titles. Although we have dental surgeons, even tree surgeons, there is considerable disquiet amongst orthopaedic surgeons about podiatrists using the title 'Surgeon' and 'Consultant'. If a podiatrist spends all day in an operating theatre performing surgery should he not be called 'Surgeon'? But use of these titles destroys the illusion of the superiority of the orthopaedic surgeon especially in the eyes of the public. Objection to the use of these titles is strong, there is clear reasoning behind it, and it will not be readily overcome by negotiation.

The beliefs I have mentioned, the ideology of professionalism, are important parts of the wider concept of medical dominance in the domain of health-care labour. Medical dominance over other occupations has been recognised ever since a clear division of labour in health-care became evident. Whilst a series of commentators have examined what they see as challenges to it, and some believe that erosion of this dominance has occurred to a greater or lesser extent, all are agreed that medical dominance continues to exist. As I have explained, the key feature in this dominance is 'control'. Controlling other health-care occupations, it is assumed, is necessary if the self-interests of the medical profession are to be preserved. These self-interests are essentially wealth, status, and prestige. Larkin (1983) reports that, in a number of ways, paramedical occupations have, over the years, wrested some control away from the medical profession without ever seriously affecting its dominance. Podiatric surgery is such an example; it has been successful in determining the boundaries of its competence, something no other paramedical occupation has ever been able to do. In this respect it has succeeded in challenging the control of the medical profession. However, is the orthopaedic surgery speciality ready to jeopardise its self-interests – wealth, status, and prestige – by negotiating away any further levels of control over a paramedical occupation?

8.2 Future Research

I have two recommendations for future research. Firstly, since undertaking this research project there has been an interesting development in Scotland. In 2004 a collaboration was announced between the two Schools of Podiatry in Scotland and two orthopaedic teaching hospitals, one in Dundee and one in Glasgow (*Podiatry Now*, July 2004). The Schools of Podiatry, affiliated to Glasgow Caledonian University and Queen Margaret University College, Edinburgh, are to offer a Masters Degree in the Theory of Podiatric Surgery.

Successful completion of this degree would open the way to practical training in foot surgery at the named hospitals. The training programme will be validated by the Royal College of Surgeons (Edinburgh) and the Royal College of Physicians and Surgeons (Glasgow). This development is surprising in many ways. It does, of course, represent a huge departure from the autonomous outlook of the podiatric surgery speciality and from orthopaedics who have never previously attempted, formally, to become involved in training podiatrists in foot surgery. Interestingly, at this stage, there is no indication that the orthopaedic bodies in England are planning similar moves though, of course, they are doubtless monitoring the progress of the Scottish development. It is also surprising because, at present, there are no podiatric surgeons to be found in Scotland and, therefore, this development cannot have been prompted by any form of adverse interaction.

Interviews with orthopaedic surgeons from Scotland made reference to the initiative but no-one intimately involved with the scheme was actually interviewed. The *Podiatry Now* (July, 2004) article stated that the programme 'meets the needs and aspirations of NHS Scotland'. This is a vague description and does not explain what has stimulated this development. However, Borthwick and Dowd (2004) suggest it is a 'pre-emptive strike' by orthopaedic surgeons in Scotland with the intention of controlling the practice of podiatric surgery in that area before it becomes established in a form they would not favour. In support of this view, Borthwick and Dowd quote from the minutes of a meeting of the Council of the Royal College of Surgeons in Edinburgh:

> There were many concerns about the development of podiatric surgery; however, it seemed inevitable that podiatrists would be allowed to work in the NHS in Scotland and it would, thus, be best to supervise this development rather than be excluded.....Professor A felt that if we were not involved in this, it would happen anyway and there would be a group of people in independent practice whom we would have no control over.
>
> (Minutes, RCSEd Council, 2002, cited in Borthwick and Dowd, 2004)

Future research could focus on, firstly, those orthopaedic surgeons centrally involved in this initiative. Does the extract from the minutes of the Council meeting accurately reflect their motives in undertaking this initiative? If controlling podiatric surgery is their aim, how extensive do they envisage this control will become? What type of podiatric practitioner do they expect to result from this collaboration? Likewise, for podiatrists involved in promoting this initiative (which appear to be non-surgical practitioners), what do they believe can be achieved? Do they see this development as relinquishing control over podiatric surgery to orthopaedic surgeons?

Secondly, research could examine the results of the programme, say, 5 years after the first graduates have been practising. What attitudes will be found at that time among both orthopaedic surgeons and podiatrists? How will those attitudes have changed from those demonstrated in this current research? As a result, should changes be made to the nature of the procedures I have recommended to facilitate better interaction between podiatric and orthopaedic surgeons?

My second suggestion for future research involves replicating my study in the American health-care environment. The USA is the only other country where podiatrists practise surgery to the extent it is performed in Britain and where, therefore, there is such a potential for conflict. On the whole American podiatrists perform a greater amount of surgery and their scope of practice is more extensive although, in some states, the practice is completely banned. Podiatric surgery has featured as a therapy in America for a longer time than in Britain and there are anecdotal reports of similar forms of conflict with orthopaedic foot surgeons to those experienced by British podiatric surgeons. An important difference between the two situations is that the USA has nothing to compare with the NHS. As a result, health-care in the USA is essentially all provided on a private basis. What this means, of course, is that there is more competition for direct financial

rewards. Does this increase the American orthopaedic surgeon's desire to control the American podiatric surgeon? Has the American podiatric surgeon developed similar strategies to his/her British counterpart in order to combat attempts to restrict their professional progress? A comparison of findings would be valuable and establish if my results and implications have wider application.

Chapter 9
Conclusion

So, what is one to make of this interprofessional conflict? In the previous chapters I examined the views of both groups involved in this conflict. Orthopaedic surgeons expressed a range of opinions regarding podiatric surgery. Podiatric surgeons have indicated a willingness to explore possibilities of working more closely with orthopaedic surgeons, but have also indicated they have strong reservations about the conditions under which this could occur. Is there a way forward for a satisfactory working relationship to be established between the two disciplines? Though I make recommendations for ways in which relations could be improved, on the basis of the evidence and arguments presented, the reader should be able to arrive at their own conclusion.

In this final chapter I summarise the key developments in the health-care arena which have resulted in conflict between orthopaedic and podiatric surgeons. I then return to the questions I outlined in Chapter 1. They were, firstly, How widespread is resistance by orthopaedic surgeons to the development of podiatric surgery and what form does such resistance take? Secondly, How have podiatric surgeons dealt with this resistance? Thirdly, What reasons lie behind resistance? Finally, Is there a willingness among orthopaedic and podiatric surgeons to develop a more satisfactory working relationship? Having attempted to address these questions, I conclude by providing a summary of recommendations which could be adopted in any approach to improve relations between the two disciplines.

9.1 NHS changes and the emergence of podiatric surgery

In the early 1990s podiatric surgery began to be viewed as a serious provider of foot surgery within the NHS. Its emergence at this time was largely due to Health Service

reforms which served to put hospital services, notably hospital consultants, under pressure. The reforms involved demands for accountability and cost-effectiveness which were implemented by Health Service managers and received support from an alleged rise in consumerism, and from the media. While the expansion of podiatric surgery in the NHS was facilitated by these demands, as quality and cost-effectiveness of the service could be demonstrated, the demands also created a climate of general mistrust and suspicion amongst hospital consultants. There has been criticism of the theories of proletarianization and deprofessionalisation but both have some utility for hospital consultants during this period, especially those within the speciality of orthopaedic surgery. In the case of proletarianization there were challenges to consultants' autonomy although commentators have noted ways by which this challenge was circumvented (Derber et al 1990). With regard to deprofessionalisation there were increased demands on consultants from various sources and a lack of public confidence was highlighted with possible repercussions for maintaining authority over clients. For orthopaedic surgeons the theory of deprofessionalisation seemed to have applicability since the emergence of podiatric surgery presented them with the danger of losing their monopoly over foot surgery. For many orthopaedic surgeons this must have seemed like 'the final straw'. Not only was there a need to contend with managerial demands and changes which challenged their authority over their own work, they were now faced with a competitor over whom they had no control. Furthermore, this competitor apparently had the capacity to 'steal' a significant amount of their work as it appeared to be favoured by both Health Service managers and the public. In the years since the early 1990s podiatric surgery has capitalised on the opportunity to become established as a service in many NHS districts but the impression amongst orthopaedic surgeons that they are under pressure from society has persisted. Indeed, this impression may have increased as a result of the focus of the NHS changing

from 'marketisation' to 'managed care' following Labour's victory at the 1997 General Election. Since that time the medical profession has faced increasing demands for accountability and the imposition of clinical guidelines or protocols have represented a further challenge to medical autonomy. Other 'new players' such as powerful drug companies and the continuing desire to promote consumerism may have added to medical disquiet and increased the perception of working within a pressurised environment (see 2.3) It seems that orthopaedic surgeons view the government, the NHS hierarchy, and the public as demanding and ever-ready to criticise their services (see 7.3 'Professional self-interests'). Against this backdrop of societal expectation and increased accountability some orthopaedic surgeons have attempted to resist the establishment of podiatric surgery. Despite reports of concern within the hierarchy of both the BOA and the RCS, organised attempts to oppose podiatric surgery have lacked commitment and have failed. It has been left to those who believe podiatric surgery should be resisted to offer individual opposition at a local level.

Podiatric surgery emerged not simply as a cheaper alternative to orthopaedic surgery but as a serious competitor with significant differences in its therapeutic approach. It formed its own knowledge base by taking what it felt was beneficial and necessary from medicine and from surgery, and added to this its own empirical knowledge concerning the mechanics, health and disease of the foot. It was found to be cost-effective, therapeutically effective, and quickly found favour with commissioning GPs and the public alike. With the government actively seeking ways of providing more economical treatments and to rein-in powerful hospital consultants, social conditions were favourable for full and formal accreditation of podiatric surgery. That this has only been partially accomplished is due to opposition from a number of orthopaedic surgeons who have prevented podiatric surgeons

from gaining full access to hospital facilities and thus denied them the chance to function at full capacity.

9.2 Opposition from orthopaedic surgeons

In the view of some orthopaedic surgeons, podiatrists should abandon surgery and return to purely conservative therapy; there is no place in the NHS, or the independent sector, for foot surgery performed by the non-medically qualified. Any form of interaction amounts to condoning an inappropriate practice and this extends to training and supervision of podiatric surgeons even though this would grant orthopaedic surgeons some control over this competing discipline. This group appears to have been responsible for the majority of the significant opposition podiatric surgeons have encountered. Opposition has taken various forms. In the absence of a legitimate right to impede podiatric surgery, this opposition has sometimes been of a trivial nature, often proven to be ineffective, and has arguably served to render the formation of a satisfactory interprofessional working relationship difficult. Overall, methods of opposition can be divided into modest, moderate, and extreme categories. Modest opposition can involve communicating suspicion and hostility – this may entail questioning the podiatric surgeon's capabilities or unpleasant interpersonal behaviour; misinformation may be fed to patients regarding the podiatric surgeon's competence or his/her surgical results. Sometimes the orthopaedic surgeon can boycott the podiatric surgery service and refuse to take part in any form of interaction, a typical course of action when one form of therapist disagrees with the activities of another (Freidson, 1970)

Moderate opposition may involve obstruction to other hospital services. This can mean attempting to persuade other service providers, such as anaesthetists, that they should not collaborate with the podiatric surgeon. The podiatric surgeon may therefore be

prevented from offering his or her patients a full range of therapy. Often, access to private hospitals is denied by orthopaedic surgeons who hold considerable power within these facilities. The most extreme form of opposition occurs when the orthopaedic surgeon actively encourages patients to undertake litigation against a podiatric surgeon. This extends beyond providing an expert opinion in a medico-legal case and can involve inciting the patient to litigation when they had not previously considered this as a possibility. All these forms of opposition may be viewed as exclusionary tactics which are essentially designed to resist the progress of podiatric surgery and protect the market position of orthopaedic surgeons (Turner, 1985) and, as such, may be viewed within the Neo-Weberian perspective (see 2.3; 4; 7.3 'The orthopaedic – podiatric relationship'). In attempting to effect occupational closure orthopaedic surgeons have not had recourse to bureaucratic help because they, as with the rest of the medical profession, have found themselves increasingly accountable to management for results and cost expenditure. Because they have been unable to show their treatment of foot disorders to be economically more viable or to be superior in terms of clinical results than that of podiatric surgery, the overall climate within the NHS has not been conducive to methods designed to exclude a competitor who appears to fulfil some of the current NHS requirements.

9.3 Dealing with opposition

Podiatric surgeons have developed various strategies to cope with this opposition. Faced with overwhelmingly superior numbers of orthopaedic surgeons in most geographical areas, podiatric surgeons have not opted for direct confrontation. Mostly they have persevered with attempts to establish an effective service in the hope that results will stand as evidence of good practice and, presumably, hope that orthopaedic surgeons will eventually come to accept their right to operate. Some have been more pro-active and

approached orthopaedics with published results of their good practice whilst others have attempted to improve communication by suggesting meetings to discuss matters of mutual interest. Overall it is difficult to assess how successful these measures have been, but they lend the impression that most have failed to change attitudes amongst orthopaedic surgeons. Despite this opposition, podiatric surgery has successfully secured a minority status in the provision of NHS foot surgery services; at the time of writing there are more than 40 consultant podiatric posts in the NHS though this is dwarfed by the number of consultant orthopaedic positions.

In terms of occupational usurpation, podiatric surgeons may be viewed as having used the political climate within the NHS over the last two decades to their advantage. As a speciality, podiatric surgery has always been more economical than orthopaedic surgery in the treatment of foot disorders mainly because it requires less staff and, in most cases, no overnight costs within hospitals. This has an obvious appeal to management striving for cost containment. The increasing amount of audit data created by podiatric surgeons has met the requirements for 'evidence based medicine' and thus satisfied bureaucratic needs leading to a greater acceptance of the speciality within the NHS. These factors have served to consolidate the position of podiatric surgery within the NHS and counter orthopaedic surgeons' attempts at occupational closure. Evidence of this is the number of current NHS consultant podiatric posts where podiatric surgeons enjoy equal status to that of orthopaedic surgeons.

9.4 Reasons for resistance

The majority of orthopaedic surgeons hold the 'middle ground' in their attitudes towards podiatric surgery, that is, they are not steadfast in their opposition and see some potential advantages in its development. Many do, however, have reservations which are often the

result of ignorance about several aspects of podiatric surgery (see 7.3 'Why is there resistance?'). The training of a podiatric surgeon is one such area. There are some dismissive attitudes with suggestions that 'people are taken off the street and taught how to do surgery' (Orthopaedic surgeon, Interview 42). While such suggestions are not, of course, to be taken literally, they do indicate that little is known about entry qualifications, length of training, content of training, nature of examinations, and under whose auspices this training is undertaken. Consistent with this is a lack of knowledge about what podiatric surgery entails – what procedures are undertaken and for what conditions. There is apparent ignorance about the anatomical confines of the podiatric surgeon's scope of practice and this ignorance has been compounded by exaggerated and erroneous anecdotal tales emanating, it seems, largely from the USA. As a result a prime concern amongst orthopaedic surgeons relates to the podiatric surgeon's scope of practice and there is a fear that there is an ever-present aspiration among podiatric surgeons to significantly increase that scope.

Although there is much published evidence of the effectiveness of podiatric surgery, and it has been commended by both the Department of Health (1994) and the King's Fund (1997), many orthopaedic surgeons are unaware of this and stress the need to see evidence of good practice before they are able to decide on the wisdom of supporting such an initiative. This may be considered rather ironic in that orthopaedic surgeons are asking for demonstrations of 'evidence based medicine' when this is one of the management tools which has served to place physicians under pressure and challenge their autonomy.

The final area of ignorance concerns regulation. Some orthopaedic surgeons understand podiatric surgeons are regulated by the CPSM (now the HPC). However, others realise that podiatric surgeons are not accountable to orthopaedic surgeons and thereby

assume they are totally unregulated. This mistaken belief causes some disquiet among those orthopaedic surgeons labouring under such a misconception.

In addition to concerns fuelled by a lack of knowledge, there are additional issues which orthopaedic surgeons would wish to see addressed before giving support to the expansion of podiatric surgery. Firstly, orthopaedic surgeons express an unwillingness to 'pick up the pieces' when podiatric surgery fails, that is, there is a belief that podiatric surgeons should be independent enough to not only perform surgery, but also deal with the post-operative complications that inevitably arise, without recourse to orthopaedic back-up.

Secondly, and not unrelated to the last point, there is a perception that increasing the level of podiatric surgery in the NHS would result in an increase in the caseload of the orthopaedic surgeon; this would not only involve dealing with post-operative complications but also mean that failures which require revision surgery would also find their way onto orthopaedic lists. This fear is largely bred from a lack of knowledge; if orthopaedic surgeons were more aware of published and objective evidence about the effectiveness of podiatric surgery, this concern may not be so great.

Finally, orthopaedic surgeons see a reduction in training opportunities for their trainees if the bulk of foot surgery passes to podiatric surgeons. Traditionally orthopaedic trainees 'cut their teeth' on the foot, a perennial concern for podiatric surgeons who offer a mirror argument to the orthopaedic one, as they claim such a practice often increases their own caseload with the need for revision surgery. For orthopaedics, though, training opportunities in foot surgery for their juniors is necessary because podiatric surgeons are never likely to be able to fully satisfy the demands for foot surgery in the UK.

There remains significant opposition amongst orthopaedic surgeons towards podiatric surgery which will not be easily overcome. There are several facets to this opposition, some stemming from a widespread lack of knowledge discussed earlier. There

is a lack of diffusion of knowledge amongst orthopaedic surgeons about podiatric surgery which has created some suspicion and mistrust; this lack of knowledge relates to virtually every aspect of the occupation. In keeping with this lack of knowledge, there is uncertainty about the efficacy of podiatric surgery, even though, as mentioned, there is much published evidence to be found in support of this. In addition to concerns about efficacy there are also worries about patient safety. There is a presumption among some orthopaedic surgeons that podiatric surgeons are 'quacks', that is, they are incapable of providing a safe and effective service. These concerns are intensified when there is little appreciation of the training a podiatric surgeon undergoes. In addition, some orthopaedic surgeons focus on podiatric surgery failures, whilst others appreciate that they are only likely to encounter podiatric failures, there being no reason for them to be presented with successful interventions. Consequently, the circulation of anecdotal evidence amongst orthopaedic surgeons is likely to concentrate on podiatric failures and a view of podiatric surgeons as 'quacks' is thus created. The lack of a medical qualification only serves to amplify the perception of 'quackery'. Whilst many orthopaedic surgeons appear to find it incredulous that non-medically qualified personnel can legitimately perform surgery, and thereby use the title 'Surgeon', they see no contradiction in dentists using the titles 'Dr' and 'Surgeon'. This reflects the absence of a territorial dispute with dentists compared to the direct conflict with podiatric surgeons. There is also disquiet about the use of the title 'Consultant' but the issue of titles would appear to be more about the belief in the superiority of orthopaedic surgeons than about concerns regarding 'quackery'.

As the questionnaire surveys and the personal interviews indicate, orthopaedic surgeons do see themselves as superior to podiatric surgeons. For a start, they possess a medical qualification which the podiatric surgeon does not have; they also undergo longer training although most do not appreciate the length and breadth of the podiatric surgeon's

training. Mostly, though, their belief in their superiority lies in their indoctrination into the ideology of professionalism (Freidson, 1970, Willis, 1994). In this ideology the professional is inherently 'superior'. The commitment they have shown in reaching their goal of attaining full professional status is such that it is beyond comparison with any outsider who approaches their domain. That outsider cannot replicate the professional's knowledge or their service orientation and is, therefore, inferior. When the professional is superior this should be acknowledged by the use of appropriate titles and their availability to inferiors should therefore be forbidden. When inferiors are given access to such titles the situation must be opposed by formal or informal means. Whilst the theoretical framework on which this research is based regards orthopaedic and podiatric surgery as disciplines of equal ability that are competing for occupational territory, it seems that some orthopaedic surgeons do not recognise this. It may be that they see relations between the two as more akin to the situation of half-a-century ago where the orthopaedic surgeon enjoyed much higher status than the chiropodist, partly because the orthopaedic surgeon was more technically accomplished (see 4; 7.3 'Why is there resistance?')

A further reason for opposition by orthopaedic surgeons towards podiatric surgery involves the suspicion and doubts that can arise when two occupations follow different philosophies of medicine. Podiatric and orthopaedic surgeons have different approaches to dealing with foot disorders. The former believe their understanding of podiatric biomechanics makes their knowledge of foot function and disorder superior to that of the orthopaedic surgeons who, with their belief in their own superiority, in turn believe that their knowledge is greater. These differences are intensified when the disciplines have adopted different terminologies, and are compounded by the reluctance of orthopaedic surgeons to interact with podiatric surgeons. Such reluctance only serves to encourage diversification and differences become consolidated if not amplified (Freidson, 1970).

Earlier, I noted Tousijn's (2006) view that 'multi-professionalism' is an increasing trend but this appears not to be the reality for some orthopaedic surgeons who seem unwilling to explore the benefits a competing speciality may have to offer (see 2.3; 4; 7.3 'Conflicting philosophies of medicine').

Several reasons for opposition from orthopaedic surgery have been discussed and all have some application. However the over-riding reason for this opposition can be explained by the Neo-Weberian perspective – to protect self-interests and, more specifically, to preserve the market position of the profession in both the NHS and private sectors. The key to preserving this position is the maintenance of an esoteric knowledge base; this knowledge must have sufficient 'mystique' to impress the client and persuade them it is beyond their understanding and that only the professional can interpret and apply that knowledge (Turner,1995). Podiatric surgery created an alternative knowledge base that threatened this 'mystique'; more importantly it represented an alternative in the public perception and therefore threatened the monopoly of the market which orthopaedic surgery had previously enjoyed. Orthopaedic surgeons were powerless to stop the creation of this knowledge base and, hence, to stop the emergence of podiatric surgery. They could, though, attempt to contain it by the use of exclusionary tactics which involve all forms of opposition previously discussed. Though obstruction may not always have occurred with conscious intention, the underlying aim may invariably have been to exclude the opposition. When an orthopaedic surgeon directs derogatory remarks towards a podiatric surgeon this is as much a form of opposition as it is when he or she blocks a podiatric surgeon's access to private hospital facilities. These exclusionary tactics seem to have had limited effect in that they failed to significantly thwart the establishment of podiatric surgery in both the public and private sectors. When orthopaedic surgery failed to retain its exclusive mandate to provide foot surgery services, in the absence of protection from a

legal mandate, the only option left, if it was to protect its market position, was to attempt to assume control over podiatric surgery. This became even more imperative within the present climate of the NHS which, as previously discussed, has been conducive to the development of podiatric surgery at the expense of orthopaedic surgery. There is, perhaps, not so much an aspiration for control among orthopaedic surgeons as an assumption that it should be held. Orthopaedic surgeons, in the main, believe they should be consulted on the hospital appointment of a podiatric surgeon; thereafter the podiatric surgeon should be subject to the training and supervision of the orthopaedic surgeon and accountable to him or her for their surgical results. For some, this control would extend to specifying what work the podiatric surgeon could undertake with the possibility that they could be given the more menial tasks to do. In any case, there would be control over the scope of practice of the podiatric surgeon which would curtail any misconceived intention to extend that scope. Indeed, some orthopaedic surgeons would advocate reducing that scope of practice from its current limits.

Formal control would be signified by regulation of podiatric surgery by an official orthopaedic body. This would serve to deprive podiatric surgery of its independence and threaten the autonomy it regards as so important. However, for orthopaedic surgeons, it would represent a way of imposing all the forms of control previously discussed. Having first failed to resist the emergence of podiatric surgery into the NHS, then failed to contain its expansion by the use of exclusionary tactics, regulation by an orthopaedic body could allow orthopaedic surgery to annex or incorporate the practices of its competitor and thereby exert a form of control not otherwise possible. In this way orthopaedic surgeons would gain the upper hand over podiatric surgeons and thereby remain the more powerful group within the disputed occupational territory even though occupational closure had not been achieved. However, as podiatric surgeons see the issue of autonomy as non-negotiable

this appears a remote possibility as any reduction in their autonomy would represent a setback in their aspirations towards improved or equal status (see 7.3 'Control').

9.5 A willingness to interact

Orthopaedic surgeons who have accepted the presence of podiatric surgeons and have been open to investigating what they have to offer, have found their practices to be a cost-effective alternative treatment, particularly to some of the less complex forms of foot surgery. In those Health Service districts where most successful relations have been established, benefits are seen from collaboration which can take the form of reciprocally referring patients, integrating services into one hospital directorate, and holding joint consultation clinics. Where an integrated service exists, orthopaedic surgeons have seen their waiting lists decrease as certain types of disorder can be addressed by collaborating podiatric surgeons. There is a realisation that, by podiatric surgeons relieving them of a significant amount of foot surgery, they are able to devote more effort to satisfying other demands.

In these circumstances, the chief benefit is seen by podiatrists to be improved patient care, though they also rate highly the improved interprofessional relations. There is appreciation that there can be exchange of ideas and skills, and that both disciplines can recognise members of the other as practitioners of equal standing. For podiatric surgeons who seldom have hospital admittance rights or access to facilities such as general anaesthesia, successful collaboration creates the opportunity to use the full range of hospital services and maximise their contribution to foot health-care.

Whilst views vary among orthopaedic surgeons on the practice of podiatric surgery and there is uncertainty about the merits of the two disciplines joining in some form of formal union, podiatric surgeons tend to view the prospect of a more formal working

relationship with orthopaedics very favourably despite having experienced opposition from the latter. They see a form of collaboration as leading to improved health-care with opportunities to improve their profession in terms of working practices and status. In short, they see potential advantages as mirroring those which have already materialised in certain localised areas where successful interaction has been established.

As strongly as podiatric surgeons appear to welcome closer collaboration with orthopaedic surgeons, they seem resolute that any relationship should be on a partnership basis. Evidence from this study suggests they are not prepared to play a subservient role to orthopaedic surgeons and that they fiercely defend their right to autonomy. Podiatric surgeons see their discipline as having endured sceptism, criticism, and resentment ever since their speciality first emerged in Britain more than 30 years ago. As a result, they do not appear ready to relinquish the autonomy they have gained and protected during that period in return for the official acknowledgement of the orthopaedic surgery profession. Podiatric surgeons would, therefore, seem happy to enjoy a form of upward mobility but are not prepared to sacrifice what they regard as one of their fundamental principles to achieve this (see 7.3 'Podiatric Surgeons').

9.6 To improve relations

Amongst those orthopaedic surgeons who are neither strongly pro nor strongly anti-podiatric surgery, are many who favour entering into dialogue with podiatric surgeons with a view to promoting a better working relationship. The consensus is that official negotiations between governing bodies are less likely to succeed in creating a climate for improving relations than local initiatives. Advocates warn that there must first be a disposition for co-operation. This disposition must be apparent in both disciplines. There needs to be flexibility in approach, a willingness to negotiate, and no intention to dictate

terms. Successful negotiation could, in turn, lead to some form of active collaboration. For this to be achieved podiatric surgeons must be prepared to address concerns which are to be found among orthopaedic surgeons. As many of these concerns stem from the latter's lack of knowledge, podiatric surgeons should be prepared to provide information about all aspects of podiatric surgery and evidence of its competence to provide a safe and effective service.

Orthopaedic surgeons need to approach the prospect of collaboration without the assumption they will 'control' podiatric surgeons. There is a necessity to recognise podiatric surgeons as independent, autonomous practitioners who may have a different approach to foot surgery but who are, nevertheless, capable of contributing to an improved and comprehensive foot-health service. If both disciplines are willing to enter into negotiations on this basis, there is a possibility that the examples of successful collaboration to be found in certain regions could be replicated. While most podiatric surgeons appear willing to explore such possibilities, this will prove difficult if a significant number of orthopaedic surgeons remain steadfast in their opposition to podiatric surgery.

9.7 Medical dominance and podiatric surgery

Podiatric surgery has made some sizeable gains over the last 30 years marked, in recent times, by a certain upward mobility with regard to its previous position and indicated by improvements in status and prestige. It has not destroyed the pre-eminence of orthopaedic surgery in the provision of foot surgery in this country; orthopaedic surgeons continue to dominate the field in terms of numbers of practitioners and numbers of surgical procedures undertaken. If one subscribes to Freidson's (1970) definition of professional dominance being the situation whereby one occupation can determine the work content of another, then podiatric surgery has challenged the dominance of orthopaedic surgeons in the field of foot

surgery, notwithstanding that, as Boyce (2006:522) notes 'it is possible to wrest aspects of control from medicine without necessarily successfully challenging or overriding medical dominance' (see 2.2).

Does the relative success of podiatric surgery have implications for the wider concept of medical dominance in health-care? It is agreed that medical dominance is being challenged and that other practitioners, and even patients, are making inroads into what were once exclusively medical domains (Annandale, 1998). It is tempting to view podiatrists as a unique case in that they have successfully identified a discrete area of work which could be separated away from its traditional base within medicine, and gone on to develop this area into a speciality in its own right. Is it likely that a similar process could occur in another area of health-care? To answer this question one should first remember that, as recently as the 1970s, it probably seemed inconceivable that a speciality such as podiatric surgery could evolve to the extent that it could offer a significant challenge to orthopaedic surgery. Today, there are other health-care occupations that have made notable advances in recent years in competence and status. Perhaps the best example of this is the emergence of the nurse-practitioner who is no longer totally dependent on the direction of the doctor. She or he has limited rights of diagnosis and the capacity to prescribe certain drugs. One may speculate how this role may expand in future in the ever-changing world of health-care, and what other challenges to medical dominance may occur as other occupations seek to develop their scope of practice.

Returning to foot health-care, orthopaedic surgeons continue to see their dominant position as essential especially with the need to protect their market position – this is important in the public sector but even more so in the private. Larkin (1983) has stressed the importance to a profession of state support. The state, in the form of the NHS, has failed to offer orthopaedic surgery protection, which means, of course, there is no bureaucratic

protection. The exclusive mandate once granted by society has been removed. It seems, then, that when a profession is deprived of any form of legal or societal protection it is vulnerable to encroachment from a competitor. When this competition becomes serious, that profession may, in desperation, seek to protect its position by any available means. Gaining some form of control over the competitor is imperative if that protection is to be achieved and formal control, by way of incorporation or annexation, is the most assured way of securing this. However, an affiliation which gives orthopaedic surgeons the right to reassert their dominance in the area of foot surgery seems unlikely given podiatric surgeons' insistence on maintaining their autonomy. It remains to be seen what sort of formal association, if any, may occur between orthopaedic and podiatric surgeons. But, if orthopaedic surgeons seek to exert control over the practice of podiatric surgery, the most they may hope for could be what Abbott (1988) terms a 'advisory jurisdiction', that is, the right to 'interpret, buffer, or partially modify' the actions of the podiatric surgeon. If some manner of formal association between the two disciplines was possible, maybe creating a shared jurisdictional settlement (Abbott, 1988), this could have potential benefits for patient care. At present both specialities have their own attributes which are not always most efficiently applied to patient care. Working in collaboration, the service both parties could offer would be more comprehensive and could only benefit health-care in general (see 2.1; 7.4).

9.8 A final note: reflections on methodology

Overall I believe the methodology employed in this research has been appropriate to the questions raised. I amassed a considerable amount of data which fulfilled my objectives; the quantitative results revealed a breadth of information from both orthopaedic and podiatric surgeons while the qualitative data gained from orthopaedic surgeons provided

qualitative detail. However, with hindsight there are three areas in which I could have approached the process differently. Firstly, I have explained my reasons for not conducting personal interviews with podiatric surgeons; these were essentially about the wish to reduce both time and expense which I felt was justified given my existing knowledge of the views of my peers towards orthopaedic surgeons. I also felt that, in this case, sufficient data would be generated from the questionnaires. However, on reflection, some personal interviews may have further enriched the valuable data generated by the questionnaires. In support of this suggestion, I was somewhat surprised at the level of co-operation some podiatric surgeons had experienced from orthopaedic surgeons, and at the willingness of podiatric surgeons to establish formal ties with orthopaedic surgeons given the appropriate circumstances. As I admitted in Chapter 5, my 'insider' status had led me to erroneous assumptions about both these issues. Consequently it is likely that personal interviews could have provided informants with an opportunity to elaborate upon their views on such issues, adding richness to detail. The additional area of investigation I referred to in Chapter 5 involved the strategies podiatric surgeons have employed in the face of opposition by orthopaedic surgeons. I commented that it is difficult to know how successful these strategies had been and perhaps personal interviews could have shed some light on this as well as providing an insight into how podiatric surgeons were made to feel by this opposition.

Secondly, the orthopaedic questionnaires could have been piloted. It would not have been appropriate to do so with podiatric surgeons because of the small number of respondents to be surveyed. With the former, I erroneously believed that responses would be poor and that numbers could not be expended in a pilot study. As it happened, as over seven hundred questionnaires were returned, a small number could have been utilised to pilot the questionnaires. The benefits of piloting chiefly involve avoiding ambiguity in the

wording of questions though, as I explained in Chapter 5, there was little indication from the returned questionnaires that any notable ambiguity had, in fact, arisen during their completion.

The final area of methodology which may have benefited from a different approach involves the interests of orthopaedic surgeons in private practice. As I noted in Chapter 7, the issue of private practice surfaced repeatedly in the data collected from both orthopaedic and podiatric surgeons. It appeared, however, almost as a hidden agenda and never materialised as a 'front-line' topic. This is understandable as a pre-occupation with private-practice would sit uneasily with those professionals who traditionally espouse the virtues of selflessness and altruism. Despite this my contention is that a prime reason behind orthopaedic surgeons' resistance to podiatric surgery is to protect their professional self-interests and private-practice would be paramount amongst these. As a result, the questionnaires for orthopaedic surgeons may have explored views on podiatric surgeons' involvement (encroachment on?) in private practice; this could have facilitated elaboration on the issue in the personal interviews. Of these three areas of adjustment to my methodology, this latter one would, I believe, have been the most significant and, possibly, the most productive. However, this presumption should be tempered by recognition of the sensitive nature of the subject which means that worthwhile disclosure by respondents/interviewees could by no means be guaranteed, regardless of how questions on private practice had been phrased.

In my final observation I return to the issue of being an 'insider' (podiatric surgeon) with regard to a situation I was investigating as an 'outsider' (researcher). In Chapter 1 I explained that I found the auto/biographical approach difficult because, as a podiatrist, I had been trained in more 'objective' science; I therefore had to make adjustments in both writing style and general outlook, in that I had to appreciate that objectivity does not have

to be absolute in sociological research. The fact that subjectivity is acceptable not only permitted me to participate as both an 'insider' and an 'outsider', it also allowed me to approach such important areas as data interpretation with a certain freedom which could have been denied by strict observance of 'objectivity'. I found this freedom helpful in writing this account because my 'insider' status makes me naturally sympathetic to the podiatric surgeon, an attitude I felt unable to deny and which has, no doubt, found expression in my writing. I noted earlier that reliable research instruments were used in order to maintain some impartiality and from these much valuable data was generated. It may be argued that the nature of the data means that a complete 'outsider', in other words a researcher who is not a podiatric surgeon, might arrive at conclusions not dissimilar to my own. However, an increased acknowledgement of subjectivity (which an inside perspective brings) can lead to an increased degree of reflexivity and I hope that such a benefit has influenced my interpretation of material and its presentation.

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Appendices

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Orthopaedics Questionnaire

Please answer the following {tick box where appropriate}. All information received will be treated with confidentiality. Such information will be used for research purposes and will involve a guarantee of anonymity.

1. a. Male ☐ Female ☐

b. Age:

c. County/counties in which you mainly work:

2. **In the treatment of your own patients have you encountered the results of previous podiatric surgery?**

YES ☐ NO ☐ UNSURE ☐

[If YES please go to question 3; if NO or UNSURE please go to question 6.]

3. **How many examples of previous podiatric surgery have you encountered?**

a. 1 case ☐

b. 2-5 cases ☐

c. 6-9 cases ☐

d. 10+ cases ☐

PLEASE TURN OVER

4a. With regard to **technical results**, did you consider the overall effects of these procedures:

i. mainly satisfactory ☐

ii. mainly unsatisfactory ☐

iii. neither ☐

4b. If mainly unsatisfactory please tick which technical failures you have encountered.

Non-correction of deformity ☐

Joint instability ☐

Transference of pressure from from operative site onto other areas ☐

Unacceptable reduction of joint range of motion ☐

Persistent pain beyond normal post-operative duration ☐

Infection ☐

Other [please specify]: .....
.....
.....
.....
.....
.....
.....
.....

5. With regard to **patient satisfaction**, did you consider the overall results of these procedures:

a. mainly satisfactory ☐

b. mainly unsatisfactory ☐

c. neither ☐

6. **Professional opinion is divided on whether more podiatric surgery should be available in the NHS. Please indicate whether you agree or disagree with the following statements by placing a tick in the most appropriate box.**

a. **An increase in the availability of *podiatric surgery* in the NHS would lead to a decrease in orthopaedic waiting lists.**

Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
☐	☐	☐	☐	☐

b. **The cost of providing more *podiatric surgery* posts in the NHS would be better spent on other aspects of health care.**

Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
☐	☐	☐	☐	☐

c. **An increase in the availability of *podiatric surgery* in the NHS would increase levels of patient satisfaction**

Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
☐	☐	☐	☐	☐

d. **An increase in *podiatric surgery* within the NHS would result in more cases needing the attention of the orthopaedic surgeon**

Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
☐	☐	☐	☐	☐

e. **An increase in *podiatric surgery* within the NHS would result in financial savings to the NHS**

Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
☐	☐	☐	☐	☐

PLEASE TURN OVER

7. A series of statements follows which relates to podiatric surgery. Please indicate your opinion by placing a tick in the appropriate box.

Podiatric surgeons:

a. should not practice because they are not medically qualified practitioners

Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
☐	☐	☐	☐	☐

b. generally accept the scope and limitations of their work

Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
☐	☐	☐	☐	☐

c. should only practice under the guidance of an orthopaedic surgeon.

Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
☐	☐	☐	☐	☐

d. are suitably qualified and trained for the work they undertake.

Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
☐	☐	☐	☐	☐

8. There is sometimes confusion about the areas involved in podiatric surgery. In your view which of the following best describes the current situation?

Podiatric surgery is confined to:

a. the knee and all areas distal to the knee ☐

b. the ankle, the hindfoot, and the forefoot ☐

c. the hindfoot and the forefoot ☐

d. the forefoot only ☐

9. Given that podiatric surgeons are regulated by the Council for Professions Allied to Medicine, do you believe the BOA should further regulate podiatric surgery?

YES ☐ NO ☐ UNSURE ☐

10. In your view what would be the advantages/disadvantages of such regulation? .....

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[If you require more space for comments on this or any other topic please continue overleaf].

11. In order to further explore some of these issues it would be helpful to conduct some personal interviews; such interviews would take about 20 minutes and be held at the convenience of the interviewee. If you would be willing to be interviewed please indicate below which form of interview you would prefer and provide a name and contact address/number.

In-person interview only ☐ Telephone interview only ☐

Either telephone or in-person interview ☐

Name: Contact address/number:

Thank you for your co-operation; now please post the questionnaire in the accompanying s.a.e.

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Podiatric Surgery Questionnaire

Please answer the following (tick box where appropriate). All information received will be treated with confidentiality. Such information will be used for research purposes and will involve a guarantee of anonymity

1. a. Male ☐ Female ☐

b. Age:

c. County/counties in which you mainly work:

2. In a typical month, does your number of surgery sessions total:

1 – 7 ☐ 8 – 14 ☐ 15 – 21 ☐ 22 or more ☐

3. In the course of your practice have you experienced any form of professional contact with orthopaedic surgery?

YES ☐ NO ☐

If answering NO, please go to question 7.

PLEASE TURN OVER

If answering YES please continue below.

4. Has this professional contact been:

Very satisfactory	Satisfactory	Unsure	Unsatisfactory	Very unsatisfactory
☐	☐	☐	☐	☐

If you answered Very satisfactory or Satisfactory please go to question 5, If you answered Very unsatisfactory or Unsatisfactory please go to question 6. If you answered Unsure please go to question 7.

5. a. Please briefly explain the nature of the satisfactory contact:

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(If you require more space for comments on this or any other topic please continue on page 5).

b. Please list any advantages (or disadvantages) of the satisfactory contact:

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Please go to question 7.

6. a. Please explain the nature of the unsatisfactory contact:

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(If you require more space for comments on this or any other topic please continue on page 5.)

b. Please describe any strategies you have employed in an attempt to overcome this unsatisfactory contact:

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7. In your opinion, would the establishment of a more formal working relationship between podiatric and orthopaedic surgeons be:

Very desirable	Desirable	Unsure	Undesirable	Very undesirable
☐	☐	☐	☐	☐

PLEASE TURN OVER

Please explain the reasons for your answer:

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8. If the opportunity arose would you consider working under the direction of orthopaedics in a dedicated foot-care team?

Yes	Maybe	Unsure	No
☐	☐	☐	☐

Please explain the reasons for your answer:

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9. In order to further explore some of these issues it would be helpful to conduct a telephone interview which would be held at your convenience. If you would be willing to be interviewed by telephone please indicate below and provide a name and contact address/number.

Name: **Contact address/number:**

FURTHER COMMENTS:

Thank you for your co-operation; now please post the questionnaire in the accompanying s.a.e.

Gender of orthpaedic surgeons

Statistics

gender

N	Valid	647
	Missing	4
Mode		1.00

gender

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	male	637	97.8	98.5	98.5
	Female	10	1.5	1.5	100.0
	Total	647	99.4	100.0	
Missing	System	4	.6		
Total		651	100.0		

Ages of orthopaedic surgeons

Appendix 4

Age in years

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	36.00	2	.3	.3	.3
	37.00	8	1.2	1.3	1.6
	38.00	16	2.5	2.5	4.1
	39.00	25	3.8	4.0	8.1
	40.00	25	3.8	4.0	12.1
	41.00	25	3.8	4.0	16.1
	42.00	41	6.3	6.5	22.6
	43.00	29	4.5	4.6	27.2
	44.00	22	3.4	3.5	30.7
	45.00	24	3.7	3.8	34.5
	46.00	32	4.9	5.1	39.6
	47.00	21	3.2	3.3	42.9
	48.00	25	3.8	4.0	46.9
	49.00	17	2.6	2.7	49.6
	50.00	22	3.4	3.5	53.1
	51.00	20	3.1	3.2	56.3
	52.00	21	3.2	3.3	59.6
	53.00	14	2.2	2.2	61.8
	54.00	20	3.1	3.2	65.0
	55.00	25	3.8	4.0	69.0
	56.00	27	4.1	4.3	73.3
	57.00	17	2.6	2.7	76.0
	58.00	26	4.0	4.1	80.1
	59.00	16	2.5	2.5	82.7
	60.00	19	2.9	3.0	85.7
	61.00	17	2.6	2.7	88.4
	62.00	12	1.8	1.9	90.3
	63.00	8	1.2	1.3	91.6
	64.00	9	1.4	1.4	93.0
	65.00	10	1.5	1.6	94.6
	66.00	7	1.1	1.1	95.7
	67.00	8	1.2	1.3	97.0
	68.00	2	.3	.3	97.3
	69.00	1	.2	.2	97.5
	70.00	3	.5	.5	97.9
	71.00	2	.3	.3	98.3
	72.00	5	.8	.8	99.0
	73.00	2	.3	.3	99.4
	74.00	1	.2	.2	99.5
	77.00	2	.3	.3	99.8
	86.00	1	.2	.2	100.0
	Total	629	96.6	100.0	
Missing	System	22	3.4		
Total		651	100.0		

Statistics

Age in years

N	Valid	629
	Missing	22
Mean		50.6407
Range		50.00

Geographical regions - orthopaedic surgeons. Appendix 5

Statistics

region

N	Valid	455
	Missing	196

region

		Frequency	Percent	Va5d Percent	Cumulative Percent
Valid	North-West	57	8.8	12.5	12.5
	East	25	3.8	5.5	18.0
	Midlands	61	9.4	13.4	31.4
	South-West	30	4.6	6.6	38.0
	North	46	7.1	10.1	48.1
	South-East	108	16.6	23.7	71.9
	Scotland	41	6.3	9.0	80.9
	South	38	5.8	8.4	89.2
	Wales and Borders	19	2.9	4.2	93.4
	Ireland	25	3.8	5.5	98.9
	North-East	5	.8	1.1	100.0
	Total	455	69.9	100.0	
Missing	System	196	30.1		
Total		651	100.0		

Podiatric surgery cases encountered

Appendix 6

Statistics

Previous experience of pod. surgery results

N	Valid	650
	Missing	1

Previous experience of pod. surgery results

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	353	54.2	54.3	54.3
	No	259	39.8	39.8	94.2
	Unsure	38	5.8	5.8	100.0
	Total	650	99.8	100.0	
Missing	Missing	1	.2		
Total		651	100.0		

Number of pod. surgery cases encountered

Appendix 7

Statistics

Number of cases encountered

N	Valid	353
	Missing	298
Mean		3.0255
Mode		4.00

Number of cases encountered

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	14	2.2	4.0	4.0
	2-5	124	19.0	35.1	39.1
	6-9	54	8.3	15.3	54.4
	10+	161	24.7	45.6	100.0
	Total	353	54.2	100.0	
Missing	System	298	45.8		
Total		651	100.0		

Technical results of cases encountered Appendix 8

Statistics

Technical results

N	Valid	344
	Missing	307

Technical results

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	mainly satisfactory	132	20.3	38.4	38.4
	mainly unsatisfactory	163	25.0	47.4	85.8
	neither	49	7.5	14.2	100.0
	Total	344	52.8	100.0	
Missing	missing	8	1.2		
	System	299	45.9		
	Total	307	47.2		
Total		651	100.0		

Patient satisfaction following pod. surgery

Appendix 9

Statistics

Patient satisfaction

N	Valid	339
	Missing	312
Mode		2.00

Patient satisfaction

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	mainly satisfactory	132	20.3	38.9	38.9
	mainly unsatisfactory	159	24.4	46.9	85.8
	neither	48	7.4	14.2	100.0
	Total	339	52.1	100.0	
Missing	missing	8	1.2		
	System	304	46.7		
	Total	312	47.9		
Total		651	100.0		

Increasing pod. s. would decrease ortho. lists Appendix 10

Statistics

Increasing pod surg in NHS would decrease ortho waiting lists

N	Valid	635
	Missing	16
Mode		4.00

Increasing pod surg in NHS would decrease ortho waiting lists

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	24	3.7	3.8	3.8
	Agree	169	26.0	26.6	30.4
	Neither agree nor disagree	150	23.0	23.6	54.0
	Disagree	204	31.3	32.1	86.1
	Strongly disagree	88	13.5	13.9	100.0
	Total	635	97.5	100.0	
Missing	Missing	16	2.5		
Total		651	100.0		

Costs of more pod. s. better spent elsewhere Appendix 11

Statistics

Costs of providing pod surg better spent on other health care

N	Valid	635
	Missing	16
Mode		2.00

Costs of providing pod surg better spent on other health care

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	175	26.9	27.6	27.6
	Agree	243	37.3	38.3	65.8
	Neither agree nor disagree	137	21.0	21.6	87.4
	Disagree	70	10.8	11.0	98.4
	Strongly disagree	10	1.5	1.6	100.0
	Total	635	97.5	100.0	
Missing	Missing	16	2.5		
Total		651	100.0		

More pod. s. would increase patient satisfaction Appendix 12

Statistics

Increasing pod surg in NHS would increase patient satisfaction

N	Valid	634
	Missing	17
Mode		3.00

Increasing pod surg in NHS would increase patient satisfaction

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	4	.6	.6	.6
	Agree	72	11.1	11.4	12.0
	Neither agree nor disagree	225	34.6	35.5	47.5
	Disagree	222	34.1	35.0	82.5
	Strongly disagree	111	17.1	17.5	100.0
	Total	634	97.4	100.0	
Missing	Missing	17	2.6		
Total		651	100.0		

More pod. s. would increase ortho. caseload Appendix 13

Statistics

Increasing pod surg in NHS would increase ortho surg caseload

N	Valid	635
	Missing	16
Mode		3.00

Increasing pod surg in NHS would increase ortho surg caseload

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	77	11.8	12.1	12.1
	Agree	186	28.6	29.3	41.4
	Neither agree nor disagree	211	32.4	33.2	74.6
	Disagree	152	23.3	23.9	98.6
	Strongly disagree	9	1.4	1.4	100.0
	Total	635	97.5	100.0	
Missing	Missing	16	2.5		
Total		651	100.0		

Increasing pod. s. would save NHS money Appendix 14

Statistics

Increasing pod surg in NHS would result in financial savings for NHS

N	Valid	635
	Missing	16
Mode		4.00

Increasing pod surg in NHS would result in financial savings for NHS

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	2	.3	.3	.3
	Agree	53	8.1	8.3	8.7
	Neither agree nor disagree	186	28.6	29.3	38.0
	Disagree	279	42.9	43.9	81.9
	Strongly disagree	115	17.7	18.1	100.0
	Total	635	97.5	100.0	
Missing	Missing	16	2.5		
Total		651	100.0		

Pod. surgs. should not practise as not drs. Appendix 15

Statistics

Pod surgs. should not practise because not medically qualified

N	Valid	634
	Missing	17
Mode		4.00

Pod surgs. should not practise because not medically qualified

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	142	21.8	22.4	22.4
	Agree	150	23.0	23.7	46.1
	Neither agree nor disagree	124	19.0	19.6	65.6
	Disagree	205	31.5	32.3	97.9
	Strongly disagree	13	2.0	2.1	100.0
	Total	634	97.4	100.0	
Missing	Missing	17	2.6		
Total		651	100.0		

Pod. surgs. know their limitations

Appendix 16

Statistics

Pod surgs accept scope and limitations of their work

N	Valid	636
	Missing	15
Mode		3.00

Pod surgs accept scope and limitations of their work

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	57	8.8	9.0	9.0
	Agree	187	28.7	29.4	38.4
	Neither agree nor disagree	192	29.5	30.2	68.6
	Disagree	146	22.4	23.0	91.5
	Strongly disagree	54	8.3	8.5	100.0
	Total	636	97.7	100.0	
Missing	Missing	15	2.3		
Total		651	100.0		

Pod. surgs. should work under ortho. guidance Appendix 17

Statistics

Pod surgs should only practise under guidance of ortho sug.

N	Valid	632
	Missing	19
Mode		2.00

Pod surgs should only practise under guidance of ortho sug.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	113	17.4	17.9	17.9
	Agree	182	28.0	28.8	46.7
	Neither agree nor disagree	163	25.0	25.8	72.5
	Disagree	136	20.9	21.5	94.0
	Strongly disagree	38	5.8	6.0	100.0
	Total	632	97.1	100.0	
Missing	Missing	19	2.9		
Total		651	100.0		

Pod. surgs. are suitably qualified

Appendix 18

Statistics

Pod surgs are suitably qualified and trained for work undertaken

N	Valid	634
	Missing	17
Mode		3.00

Pod surgs are suitably qualified and trained for work undertaken

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	24	3.7	3.8	3.8
	Agree	120	18.4	18.9	22.7
	Neither agree nor disagree	243	37.3	38.3	61.0
	Disagree	158	24.3	24.9	86.0
	Strongly disagree	89	13.7	14.0	100.0
	Total	634	97.4	100.0	
Missing	Missing	17	2.6		
Total		651	100.0		

Podiatric scope of practice

Appendix 19

Statistics

Pod surg is confined to:

N	Valid	612
	Missing	39
Mode		4.00

Pod surg is confined to:

		Frequency	Percent
Valid	Knee and all areas distal to knee	12	1.8
	Ankle, hindfoot, and the forefoot	109	16.7
	Hindfoot and the forefoot	129	19.8
	Forefoot only	362	55.6
	Total	612	94.0
Missing	Missing	39	6.0
Total		651	100.0

Pod surg is confined to:

		Valid Percent	Cumulative Percent
Valid	Knee and all areas distal to knee	2.0	2.0
	Ankle, hindfoot, and the forefoot	17.8	19.8
	Hindfoot and the forefoot	21.1	40.8
	Forefoot only	59.2	100.0
	Total	100.0	
Missing	Missing		
Total			

Should the BOA regulate podiatric surgery? Appendix 20

Statistics

Should BOA regulate pod surg?

N	Valid	622
	Missing	29
Mode		1.00

Should BOA regulate pod surg?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	314	48.2	50.5	50.5
	No	204	31.3	32.8	83.3
	Unsure	104	16.0	16.7	100.0
	Total	622	95.5	100.0	
Missing	Missing	29	4.5		
Total		651	100.0		

Advantages of BOA regulation of pod. s. Appendix 21

Case Summary

	Cases	
	Valid	
	N	Percent
$mradvantages[a]	192	29.5%

Case Summary

	Cases			
	Missing		Total	
	N	Percent	N	Percent
$mradvantages[a]	459	70.5%	651	100.0%

a. Group

$mradvantages Frequencies

		Responses		Percent of Cases
		N	Percent	
Advantages of BOA regulation[a]	Uniformity	27	12.2%	14.1%
	Control	71	32.0%	37.0%
	Integration	49	22.1%	25.5%
	Control of scope of practice	27	12.2%	14.1%
	Better patient care	39	17.6%	20.3%
	Improve status of podiatrists	9	4.1%	4.7%
Total		222	100.0%	115.6%

a. Group

Disadvantages of BOA regulation of pod. s. Appendix 22

Statistics

Disadvantages of regulation

N	Valid	17
	Missing	634
Mode		1.00

Disadvantages of regulation

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	BOA should not take on this responsibility and risks involve	12	1.8	70.6	70.6
	increase confusion re: role of pod surgeons	5	.8	29.4	100.0
	Total	17	2.6	100.0	
Missing	System	634	97.4		
Total		651	100.0		

Crosstabulation 1

Appendix 23

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Increasing pod surg in NHS would decrease ortho waiting lists * Previous experience of pod. surgery results	634	97.4%	17	2.6%	651	100.0%

Increasing pod surg in NHS would decrease ortho waiting lists * Previous experience of pod. surgery results Crosstabulation

			Previous experience of pod. surgery results			
			Yes	Unsure	No	Total
Increasing pod surg in NHS would decrease ortho waiting lists	Strongly agree	Count	12	1	11	24
		% within Previous experience of pod. surgery results	3.5%	2.6%	4.4%	3.8%
	Agree	Count	89	10	70	169
		% within Previous experience of pod. surgery results	26%	26%	28%	27%
	Neither agree nor disagree	Count	71	9	70	150
		% within Previous experience of pod. surgery results	21%	24%	28%	24%
	Disagree	Count	114	12	78	204
		% within Previous experience of pod. surgery results	33%	32%	31%	32%
	Strongly disagree	Count	58	6	23	87
		% within Previous experience of pod. surgery results	17%	16%	9.1%	14%
Total		Count	344	38	252	634
		% within Previous experience of pod. surgery results	****	****	****	****

Directional Measures

			Value	Asymp. Std. Error[a]
Ordinal by Ordinal	Somers' d	Symmetric	-.080	.034
		Increasing pod surg in NHS would decrease ortho waiting lists Dependent	-.095	.041
		Previous experience of pod. surgery results Dependent	-.069	.030

Crosstabulation 2

Case Processing Summary

	Cases		
	Valid		
	N	Percent	
Costs of providing pod surg better spent on other health care * Previous experience of pod. surgery results	634	97.4%	

Case Processing Summary

	Cases			
	Missing		Total	
	N	Percent	N	Percent
Costs of providing pod surg better spent on other health care * Previous experience of pod. surgery results	17	2.6%	651	100.0%

Costs of providing pod surg better spent on other health care * Previous experience of pod. surgery results Crosstabulation

			Previous experience of pod. surgery results			
			Yes	Uns ure	No	Total
Costs of providing pod surg better spent on other health care	Strongly agree	Count	110	10	55	175
		% within Previous experience of pod. surgery results	32%	26%	22%	28%
	Agree	Count	116	13	114	243
		% within Previous experience of pod. surgery results	34%	34%	45%	38%
	Neither agree nor disagree	Count	67	9	60	136
		% within Previous experience of pod. surgery results	20%	24%	24%	21%
	Disagree	Count	44	5	21	70
		% within Previous experience of pod. surgery results	13%	13%	8.3%	11%
	Strongly disagree	Count	6	1	3	10
		% within Previous experience of pod. surgery results	1.7%	2.6%	1.2%	1.6%
Total		Count	343	38	253	634
		% within Previous experience of pod. surgery results	....	....	....	....

Directional Measures

			Value	Asymp. Std. Error[a]
Ordinal by Ordinal	Somers' d	Symmetric	.036	.035
		Costs of providing pod surg better spent on other health care Dependent	.042	.040
		Previous experience of pod. surgery results Dependent	.032	.031

Crosstabulation 3

Case Processing Summary

	Cases	
	Valid	
	N	Percent
Increasing pod surg in NHS would increase patient satisfaction * Previous experience of pod. surgery results	633	97.2%

Case Processing Summary

	Cases			
	Missing		Total	
	N	Percent	N	Percent
Increasing pod surg in NHS would increase patient satisfaction * Previous experience of pod. surgery results	18	2.8%	651	100.0%

Increasing pod surg in NHS would increase patient satisfaction * Previous experience of pod. surgery results Crosstabulation

Count

		Previous experience of pod. surgery results			Total
		Yes	Unsure	No	
Increasing pod surg in NHS would increase patient satisfaction	Strongly agree	4	0	0	4
	Agree	40	3	29	72
	Neither agree nor disagree	96	14	115	225
	Disagree	130	13	79	222
	Strongly disagree	74	8	28	110
Total		344	38	251	633

Directional Measures

			Value	Asymp. Std. Error[a]
Ordinal by Ordinal	Somers' d	Symmetric	-.126	.035
		Increasing pod surg in NHS would increase patient satisfaction Dependent	-.146	.040
		Previous experience of pod. surgery results Dependent	-.112	.031

Crosstabulation 4

Case Processing Summary

	Cases		
	Valid		
	N	Percent	
Increasing pod surg in NHS would increase ortho surg caseload * Previous experience of pod. surgery results	634	97.4%	

Case Processing Summary

	Cases			
	Missing		Total	
	N	Percent	N	Percent
Increasing pod surg in NHS would increase ortho surg caseload * Previous experience of pod. surgery results	17	2.6%	651	100.0%

Increasing pod surg in NHS would increase ortho surg caseload * Previous experience of pod. surgery results Crosstabulation

			Previous experience of pod. surgery results			
			Yes	Unsure	No	Total
Increasing pod surg in NHS would increase ortho surg caseload	Strongly agree	Count	57	4	16	77
		% within Previous experience of pod. surgery results	16.6%	10.5%	6.3%	12.1%
	Agree	Count	110	10	65	185
		% within Previous experience of pod. surgery results	32.1%	26.3%	25.7%	29.2%
	Neither agree nor disagree	Count	93	13	105	211
		% within Previous experience of pod. surgery results	27.1%	34.2%	41.5%	33.3%
	Disagree	Count	75	10	67	152
		% within Previous experience of pod. surgery results	21.9%	26.3%	26.5%	24.0%
	Strongly disagree	Count	8	1	0	9
		% within Previous experience of pod. surgery results	2.3%	2.6%	.0%	1.4%
Total		Count	343	38	253	634
		% within Previous experience of pod. surgery results	100%	100%	100%	100%

Directional Measures

			Value	Asymp. Std. Error[a]
Ordinal by Ordinal	Somers' d	Symmetric	.119	.034
		Increasing pod surg in NHS would increase ortho surg caseload Dependent	.139	.040
		Previous experience of pod. surgery results Dependent	.103	.030

Crosstabulation 5

Appendix 27

Case Processing Summary

	Cases		
	Valid		
	N	Percent	
Increasing pod surg in NHS would result in financial savings for NHS * Previous experience of pod. surgery results	634	97.4%	

Case Processing Summary

	Cases			
	Missing		Total	
	N	Percent	N	Percent
Increasing pod surg in NHS would result in financial savings for NHS * Previous experience of pod. surgery results	17	2.6%	651	100.0%

Increasing pod surg in NHS would result in financial savings for NHS * Previous experience of pod. surgery results Crosstabulation

			Previous experience of pod. surgery results			
			Yes	Uns ure	No	Total
Increasing pod surg in NHS would result in financial savings for NHS	Strongly agree	Count	2	0	0	2
		% within Previous experience of pod. surgery results	.6%	.0%	.0%	.3%
	Agree	Count	29	3	21	53
		% within Previous experience of pod. surgery results	8.4%	8.1%	8.3%	8.4%
	Neither agree nor disagree	Count	98	13	75	186
		% within Previous experience of pod. surgery results	28%	35%	30%	29%
	Disagree	Count	143	12	123	278
		% within Previous experience of pod. surgery results	41%	32%	49%	44%
	Strongly disagree	Count	73	9	33	115
		% within Previous experience of pod. surgery results	21%	24%	13%	18%
Total		Count	345	37	252	634
		% within Previous experience of pod. surgery results	****	****	****	****

Directional Measures

			Value	Asymp. Std. Error[a]
Ordinal by Ordinal	Somers' d	Symmetric	-.041	.035
		Increasing pod surg in NHS would result in financial savings for NHS Dependent	-.046	.040
		Previous experience of pod. surgery results Dependent	-.037	.031

Crosstabulation 6

Case Processing Summary

	Cases	
	Valid	
	N	Percent
Pod surgs. should not practise because not medically qualified * Previous experience of pod. surgery results	633	97.2%

Case Processing Summary

	Cases			
	Missing		Total	
	N	Percent	N	Percent
Pod surgs. should not practise because not medically qualified * Previous experience of pod. surgery results	18	2.8%	651	100.0%

Pod surgs. should not practise because not medically qualified * Previous experience of pod. surgery results Crosstabulation

Count

		Previous experience of pod. surgery results			
		Yes	Unsure	No	Total
Pod surgs. should not practise because not medically qualified	Strongly agree	90	7	45	142
	Agree	74	10	66	150
	Neither agree nor disagree	49	14	61	124
	Disagree	123	6	75	204
	Strongly disagree	9	1	3	13
Total		345	38	250	633

Directional Measures

			Value	Asymp. Std. Error[a]
Ordinal by Ordinal	Somers' d	Symmetric	.006	.035
		Pod surgs. should not practise because not medically qualified Dependent	.007	.042
		Previous experience of pod. surgery results Dependent	.005	.030

Crosstabulation 7

Appendix 29

Case Processing Summary

	Cases		
	Valid		
	N	Percent	
Pod surgs accept scope and limitations of their work * Previous experience of pod. surgery results	635	97.5%	

Case Processing Summary

	Cases			
	Missing		Total	
	N	Percent	N	Percent
Pod surgs accept scope and limitations of their work * Previous experience of pod. surgery results	16	2.5%	651	100.0%

Pod surgs accept scope and limitations of their work * Previous experience of pod. surgery results Crosstabulation

			Previous experience of pod. surgery results			
			Yes	Uns ure	No	Total
Pod surgs accept scope and limitations of their work	Strongly agree	Count	42	4	11	57
		% within Previous experience of pod. surgery results	12%	11%	4.4%	9.0%
	Agree	Count	113	8	66	187
		% within Previous experience of pod. surgery results	32%	21%	27%	29%
	Neither agree nor disagree	Count	56	18	118	192
		% within Previous experience of pod. surgery results	16%	47%	48%	30%
	Disagree	Count	98	7	40	145
		% within Previous experience of pod. surgery results	28%	18%	16%	23%
	Strongly disagree	Count	40	1	13	54
		% within Previous experience of pod. surgery results	11%	2.6%	5.2%	8.5%
Total		Count	349	38	248	635
		% within Previous experience of pod. surgery results	****	****	****	****

Directional Measures

			Value	Asymp. Std. Error[a]
Ordinal by Ordinal	Somers' d	Symmetric	-.007	.035
		Pod surgs accept scope and limitations of their work Dependent	-.008	.042
		Previous experience of pod. surgery results Dependent	-.006	.030

Crosstabulation 8

Case Processing Summary

	Cases		
	Valid		
	N	Percent	
Pod surgs should only practise under guidance of ortho sug. * Previous experience of pod. surgery results	631	96.9%	

Case Processing Summary

	Cases			
	Missing		Total	
	N	Percent	N	Percent
Pod surgs should only practise under guidance of ortho sug. * Previous experience of pod. surgery results	20	3.1%	651	100.0%

Pod surgs should only practise under guidance of ortho sug. * Previous experience of pod. surgery results Crosstabulation

Count

		Previous experience of pod. surgery results			Total
		Yes	Unsure	No	
Pod surgs should only practise under guidance of ortho sug.	Strongly agree	76	3	34	113
	Agree	99	11	72	182
	Neither agree nor disagree	77	14	72	163
	Disagree	73	6	56	135
	Strongly disagree	22	3	13	38
Total		347	37	247	631

Directional Measures

			Value	Asymp. Std. Error[a]
Ordinal by Ordinal	Somers' d	Symmetric	.061	.035
		Pod surgs should only practise under guidance of ortho sug. Dependent	.074	.042
		Previous experience of pod. surgery results Dependent	.052	.029

Crosstabulation 9

Case Processing Summary

	Cases		
	Valid		
	N	Percent	
Pod surgs are suitably qualified and trained for work undertaken * Previous experience of pod. surgery results	633	97.2%	

Case Processing Summary

	Cases			
	Missing		Total	
	N	Percent	N	Percent
Pod surgs are suitably qualified and trained for work undertaken * Previous experience of pod. surgery results	18	2.8%	651	100.0%

Pod surgs are suitably qualified and trained for work undertaken * Previous experience of pod. surgery results Crosstabulation

Count

		Previous experience of pod. surgery results			
		Yes	Unsure	No	Total
Pod surgs are suitably qualified and trained for work undertaken	Strongly agree	16	1	7	24
	Agree	71	6	43	120
	Neither agree nor disagree	98	18	127	243
	Disagree	102	7	48	157
	Strongly disagree	63	5	21	89
Total		350	37	246	633

Directional Measures

			Value	Asymp. Std. Error[a]
Ordinal by Ordinal	Somers' d	Symmetric	-.097	.034
		Pod surgs are suitably qualified and trained for work undertaken Dependent	-.115	.041
		Previous experience of pod. surgery results Dependent	-.084	.030

Crosstabulation 10

Case Processing Summary

	Cases	
	Valid	
	N	Percent
Increasing pod surg in NHS would decrease ortho waiting lists * Number of cases encountered	344	52.8%

Case Processing Summary

	Cases			
	Missing		Total	
	N	Percent	N	Percent
Increasing pod surg in NHS would decrease ortho waiting lists * Number of cases encountered	307	47.2%	651	100.0%

Increasing pod surg in NHS would decrease ortho waiting lists * Number of cases encountered Crosstabulation

			Number of cases		
			1	2-5	6-9
Increasing pod surg in NHS would decrease ortho waiting lists	Strongly agree	Count	0	3	2
		% within Number of cases encountered	.0%	2.5%	3.8%
	Agree	Count	5	29	16
		% within Number of cases encountered	35.7%	24.2%	30.8%
	Neither agree nor disagree	Count	2	25	8
		% within Number of cases encountered	14.3%	20.8%	15.4%
	Disagree	Count	6	46	13
		% within Number of cases encountered	42.9%	38.3%	25.0%
	Strongly disagree	Count	1	17	13
		% within Number of cases encountered	7.1%	14.2%	25.0%
Total		Count	14	120	52
		% within Number of cases encountered	100%	100%	100%

Increasing pod surg in NHS would decrease ortho waiting lists * Number of cases encountered Crosstabulation

			Numb	
			10+	Total
Increasing pod surg in NHS would decrease ortho waiting lists	Strongly agree	Count	7	12
		% within Number of cases encountered	4.4%	3.5%
	Agree	Count	38	88
		% within Number of cases encountered	24.1%	25.6%
	Neither agree nor disagree	Count	36	71
		% within Number of cases encountered	22.8%	20.6%
	Disagree	Count	50	115
		% within Number of cases encountered	31.6%	33.4%
	Strongly disagree	Count	27	58
		% within Number of cases encountered	17.1%	16.9%
Total		Count	158	344
		% within Number of cases encountered	100%	100%

Directional Measures

			Value	Asymp. Std. Error[a]
Ordinal by Ordinal	Somers' d	Symmetric	-.004	.044
		Increasing pod surg in NHS would decrease ortho waiting lists Dependent	-.005	.048
		Number of cases encountered Dependent	-.004	.041

Case Processing Summary

	Cases		
	Valid		
	N	Percent	
Costs of providing pod surg better spent on other health care * Number of cases encountered	343	52.7%	

Case Processing Summary

	Cases			
	Missing		Total	
	N	Percent	N	Percent
Costs of providing pod surg better spent on other health care * Number of cases encountered	308	47.3%	651	100.0%

Costs of providing pod surg better spent on other health care * Number of cases encountered Crosstabulation

			Number of cases		
			1	2-5	6-9
Costs of providing pod surg better spent on other health care	Strongly agree	Count	2	36	25
		% within Number of cases encountered	14.3%	30.0%	48.1%
	Agree	Count	9	38	14
		% within Number of cases encountered	64.3%	31.7%	26.9%
	Neither agree nor disagree	Count	2	29	7
		% within Number of cases encountered	14.3%	24.2%	13.5%
	Disagree	Count	1	16	5
		% within Number of cases encountered	7.1%	13.3%	9.6%
	Strongly disagree	Count	0	1	1
		% within Number of cases encountered	.0%	.8%	1.9%
Total		Count	14	120	52
		% within Number of cases encountered	100%	100%	100%

Costs of providing pod surg better spent on other health care * Number of cases encountered Crosstabulation

			Numb 10+	Total
Costs of providing pod surg better spent on other health care	Strongly agree	Count	47	110
		% within Number of cases encountered	29.9%	32.1%
	Agree	Count	56	117
		% within Number of cases encountered	35.7%	34.1%
	Neither agree nor disagree	Count	29	67
		% within Number of cases encountered	18.5%	19.5%
	Disagree	Count	21	43
		% within Number of cases encountered	13.4%	12.5%
	Strongly disagree	Count	4	6
		% within Number of cases encountered	2.5%	1.7%
Total		Count	157	343
		% within Number of cases encountered	100%	100%

Directional Measures

			Value	Asymp. Std. Error[a]
Ordinal by Ordinal	Somers' d	Symmetric	-.002	.045
		Costs of providing pod surg better spent on other health care Dependent	-.002	.047
		Number of cases encountered Dependent	-.001	.042

Crosstabulation 12

Case Processing Summary

	Cases		
	Valid		
	N	Percent	
Increasing pod surg in NHS would increase patient satisfaction * Number of cases encountered	344	52.8%	

Case Processing Summary

	Cases			
	Missing		Total	
	N	Percent	N	Percent
Increasing pod surg in NHS would increase patient satisfaction * Number of cases encountered	307	47.2%	651	100.0%

Increasing pod surg in NHS would increase patient satisfaction * Number of cases encountered Crosstabulation

Count

		Number of cases encountered				Total
		1	2-5	6-9	10+	
Increasing pod surg in NHS would increase patient satisfaction	Strongly agree	0	2	0	2	4
	Agree	0	13	8	19	40
	Neither agree nor disagree	6	36	14	39	95
	Disagree	7	51	15	58	131
	Strongly disagree	1	19	15	39	74
Total		14	121	52	157	344

Directional Measures

			Value	Asymp. Std. Error[a]
Ordinal by Ordinal	Somers' d	Symmetric	.054	.044
		Increasing pod surg in NHS would increase patient satisfaction Dependent	.057	.047
		Number of cases encountered Dependent	.051	.042

Case Processing Summary

	Cases	
	Valid	
	N	Percent
Increasing pod surg in NHS would increase ortho surg caseload * Number of cases encountered	343	52.7%

Case Processing Summary

	Cases			
	Missing		Total	
	N	Percent	N	Percent
Increasing pod surg in NHS would increase ortho surg caseload * Number of cases encountered	308	47.3%	651	100.0%

Increasing pod surg in NHS would increase ortho surg caseload * Number of cases encountered Crosstabulation

			Number of cases		
			1	2-5	6-9
Increasing pod surg in NHS would increase ortho surg caseload	Strongly agree	Count	1	17	7
		% within Number of cases encountered	7.1%	14.0%	14.0%
	Agree	Count	7	40	20
		% within Number of cases encountered	50.0%	33.1%	40.0%
	Neither agree nor disagree	Count	4	31	15
		% within Number of cases encountered	28.6%	25.6%	30.0%
	Disagree	Count	2	31	8
		% within Number of cases encountered	14.3%	25.6%	16.0%
	Strongly disagree	Count	0	2	0
		% within Number of cases encountered	.0%	1.7%	.0%
Total		Count	14	121	50
		% within Number of cases encountered	100%	100%	100%

Increasing pod surg in NHS would increase ortho surg caseload * Number of cases encountered Crosstabulation

			Numb 10+	Total
Increasing pod surg in NHS would increase ortho surg caseload	Strongly agree	Count	32	57
		% within Number of cases encountered	20.3%	16.6%
	Agree	Count	44	111
		% within Number of cases encountered	27.8%	32.4%
	Neither agree nor disagree	Count	43	93
		% within Number of cases encountered	27.2%	27.1%
	Disagree	Count	33	74
		% within Number of cases encountered	20.9%	21.6%
	Strongly disagree	Count	6	8
		% within Number of cases encountered	3.8%	2.3%
Total		Count	158	343
		% within Number of cases encountered	100%	100%

Directional Measures

			Value	Asymp. Std. Error[a]
Ordinal by Ordinal	Somers' d	Symmetric	-.018	.047
		Increasing pod surg in NHS would increase ortho surg caseload Dependent	-.020	.051
		Number of cases encountered Dependent	-.017	.043

Crosstabulation 14

Case Processing Summary

	Cases		
	Valid		
	N	Percent	
Increasing pod surg in NHS would result in financial savings for NHS * Number of cases encountered	345	53.0%	

Case Processing Summary

	Cases			
	Missing		Total	
	N	Percent	N	Percent
Increasing pod surg in NHS would result in financial savings for NHS * Number of cases encountered	306	47.0%	651	100.0%

Increasing pod surg in NHS would result in financial savings for NHS * Number of cases encountered Crosstabulation

			Number of cases		
			1	2-5	6-9
Increasing pod surg in NHS would result in financial savings for NHS	Strongly agree	Count	0	1	0
		% within Number of cases encountered	.0%	.8%	.0%
	Agree	Count	1	9	3
		% within Number of cases encountered	7.1%	7.4%	5.8%
	Neither agree nor disagree	Count	3	36	15
		% within Number of cases encountered	21.4%	29.8%	28.8%
	Disagree	Count	9	55	21
		% within Number of cases encountered	64.3%	45.5%	40.4%
	Strongly disagree	Count	1	20	13
		% within Number of cases encountered	7.1%	16.5%	25.0%
Total		Count	14	121	52
		% within Number of cases encountered	100%	100%	100%

Increasing pod surg in NHS would result in financial savings for NHS * Number of cases encountered Crosstabulation

			Numb 10+	Total
Increasing pod surg in NHS would result in financial savings for NHS	Strongly agree	Count	1	2
		% within Number of cases encountered	.6%	.6%
	Agree	Count	16	29
		% within Number of cases encountered	10.1%	8.4%
	Neither agree nor disagree	Count	44	98
		% within Number of cases encountered	27.8%	28.4%
	Disagree	Count	59	144
		% within Number of cases encountered	37.3%	41.7%
	Strongly disagree	Count	38	72
		% within Number of cases encountered	24.1%	20.9%
Total		Count	158	345
		% within Number of cases encountered	100%	100%

Directional Measures

			Value	Asymp. Std. Error[a]
Ordinal by Ordinal	Somers' d	Symmetric	.021	.046
		Increasing pod surg in NHS would result in financial savings for NHS Dependent	.022	.048
		Number of cases encountered Dependent	.020	.044

Crosstabulation 15

Case Processing Summary

	Cases	
	Valid	
	N	Percent
Pod surgs. should not practise because not medically qualified * Number of cases encountered	345	53.0%

Case Processing Summary

	Cases			
	Missing		Total	
	N	Percent	N	Percent
Pod surgs. should not practise because not medically qualified * Number of cases encountered	306	47.0%	651	100.0%

Pod surgs. should not practise because not medically qualified * Number of cases encountered Crosstabulation

Count

		Number of cases encountered				Total
		1	2-5	6-9	10+	
Pod surgs. should not practise because not medically qualified	Strongly agree	0	28	14	48	90
	Agree	3	29	14	29	75
	Neither agree nor disagree	4	22	6	17	49
	Disagree	7	43	17	56	123
	Strongly disagree	0	1	1	6	8
Total		14	123	52	156	345

Directional Measures

			Value	Asymp. Std. Error[a]
Ordinal by Ordinal	Somers' d	Symmetric	-.043	.046
		Pod surgs. should not practise because not medically qualified Dependent	-.046	.049
		Number of cases encountered Dependent	-.040	.043

Crosstabulation 16

Appendix 38

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Pod surgs accept scope and limitations of their work * Number of cases encountered	349	53.6%	302	46.4%	651	100.0%

Pod surgs accept scope and limitations of their work * Number of cases encountered Crosstabulation

			Number of cases encountered				Total
			1	2-5	6-9	10+	
Pod surgs accept scope and limitations of their work	Strongly agree	Count	0	15	5	22	42
		% within Number of cases encountered	.0%	12.2%	9.6%	13.8%	12.0%
	Agree	Count	8	39	21	45	113
		% within Number of cases encountered	57.1%	31.7%	40.4%	28.1%	32.4%
	Neither agree nor disagree	Count	4	22	7	23	56
		% within Number of cases encountered	28.6%	17.9%	13.5%	14.4%	16.0%
	Disagree	Count	1	39	11	47	98
		% within Number of cases encountered	7.1%	31.7%	21.2%	29.4%	28.1%
	Strongly disagree	Count	1	8	8	23	40
		% within Number of cases encountered	7.1%	6.5%	15.4%	14.4%	11.5%
Total		Count	14	123	52	160	349
		% within Number of cases encountered	100%	100%	100%	100%	100%

Directional Measures

			Value	Asymp. Std. Error[a]	Approx. T[b]	Approx. Sig.
Ordinal by Ordinal	Somers' d	Symmetric	.053	.044	1.206	.228
		Pod surgs accept scope and limitations of their work Dependent	.058	.048	1.206	.228
		Number of cases encountered Dependent	.049	.041	1.206	.228

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

Crosstabulation 17

Case Processing Summary

	Cases	
	Valid	
	N	Percent
Pod surgs should only practise under guidance of ortho sug. * Number of cases encountered	347	53.3%

Case Processing Summary

	Cases			
	Missing		Total	
	N	Percent	N	Percent
Pod surgs should only practise under guidance of ortho sug. * Number of cases encountered	304	46.7%	651	100.0%

Pod surgs should only practise under guidance of ortho sug. * Number of cases encountered Crosstabulation

Count

		Number of cases encountered				Total
		1	2-5	6-9	10+	
Pod surgs should only practise under guidance of ortho sug.	Strongly agree	0	24	12	39	75
	Agree	8	36	16	40	100
	Neither agree nor disagree	1	30	9	37	77
	Disagree	5	26	11	31	73
	Strongly disagree	0	7	4	11	22
Total		14	123	52	158	347

Directional Measures

			Value	Asymp. Std. Error[a]
Ordinal by Ordinal	Somers' d	Symmetric	-.029	.044
		Pod surgs should only practise under guidance of ortho sug. Dependent	-.032	.049
		Number of cases encountered Dependent	-.026	.041

Crosstabulation 18

Case Processing Summary

	Cases		
	Valid		
	N	Percent	
Pod surgs are suitably qualified and trained for work undertaken * Number of cases encountered	350	53.8%	

Case Processing Summary

	Cases			
	Missing		Total	
	N	Percent	N	Percent
Pod surgs are suitably qualified and trained for work undertaken * Number of cases encountered	301	46.2%	651	100.0%

Pod surgs are suitably qualified and trained for work undertaken * Number of cases encountered Crosstabulation

Count

		Number of cases encountered		
		1	2-5	6-9
Pod surgs are suitably qualified and trained for work undertaken	Strongly agree	1	4	0
	Agree	2	28	11
	Neither agree nor disagree	6	38	14
	Disagree	4	36	17
	Strongly disagree	1	17	12
Total		14	123	54

Pod surgs are suitably qualified and trained for work undertaken * Number of cases encountered Crosstabulation

Count

		Number of	
		10+	Total
Pod surgs are suitably qualified and trained for work undertaken	Strongly agree	11	16
	Agree	29	70
	Neither agree nor disagree	40	98
	Disagree	46	103
	Strongly disagree	33	63
Total		159	350

Directional Measures

			Value	Asymp. Std. Error[a]
Ordinal by Ordinal	Somers' d	Symmetric	.050	.045
		Pod surgs are suitably qualified and trained for work undertaken Dependent	.054	.049
		Number of cases encountered Dependent	.046	.042

Case Processing Summary

	Cases		
	Valid		
	N	Percent	
Increasing pod surg in NHS would decrease ortho waiting lists * Technical results	341	52.4%	

Case Processing Summary

	Cases			
	Missing		Total	
	N	Percent	N	Percent
Increasing pod surg in NHS would decrease ortho waiting lists * Technical results	310	47.6%	651	100.0%

Increasing pod surg in NHS would decrease ortho waiting lists * Technical results Crosstabulation

			Technical	
			mainly satisfactory	neither
Increasing pod surg in NHS would decrease ortho waiting lists	Strongly agree	Count	10	1
		% within Technical results	7.6%	2.1%
	Agree	Count	54	8
		% within Technical results	40.9%	16.7%
	Neither agree nor disagree	Count	32	12
		% within Technical results	24.2%	25.0%
	Disagree	Count	31	21
		% within Technical results	23.5%	43.8%
	Strongly disagree	Count	5	6
		% within Technical results	3.8%	12.5%
Total		Count	132	48
		% within Technical results	100%	100%

Increasing pod surg in NHS would decrease ortho waiting lists * Technical results Crosstabulation

			Techn mainly unsatisfactory	Total
Increasing pod surg in NHS would decrease ortho waiting lists	Strongly agree	Count	1	12
		% within Technical results	.6%	3.5%
	Agree	Count	25	87
		% within Technical results	15.5%	25.5%
	Neither agree nor disagree	Count	27	71
		% within Technical results	16.8%	20.8%
	Disagree	Count	61	113
		% within Technical results	37.9%	33.1%
	Strongly disagree	Count	47	58
		% within Technical results	29.2%	17.0%
Total		Count	161	341
		% within Technical results	100%	100%

Directional Measures

			Value	Asymp. Std. Error[a]
Ordinal by Ordinal	Somers' d	Symmetric	.368	.041
		Increasing pod surg in NHS would decrease ortho waiting lists Dependent	.412	.047
		Technical results Dependent	.333	.037

Crosstabulation 20

Case Processing Summary

	Cases		
	Valid		
	N	Percent	
Costs of providing pod surg better spent on other health care * Technical results	340	52.2%	

Case Processing Summary

	Cases			
	Missing		Total	
	N	Percent	N	Percent
Costs of providing pod surg better spent on other health care * Technical results	311	47.8%	651	100.0%

Costs of providing pod surg better spent on other health care * Technical results Crosstabulation

			Technical	
			mainly satisfactory	neither
Costs of providing pod surg better spent on other health care	Strongly agree	Count	17	17
		% within Technical results	12.9%	35.4%
	Agree	Count	40	16
		% within Technical results	30.3%	33.3%
	Neither agree nor disagree	Count	40	10
		% within Technical results	30.3%	20.8%
	Disagree	Count	31	4
		% within Technical results	23.5%	8.3%
	Strongly disagree	Count	4	1
		% within Technical results	3.0%	2.1%
Total		Count	132	48
		% within Technical results	100%	100%

Costs of providing pod surg better spent on other health care * Technical results Crosstabulation

			Techn mainly unsatisfactory	Total
Costs of providing pod surg better spent on other health care	Strongly agree	Count	76	110
		% within Technical results	47.5%	32.4%
	Agree	Count	58	114
		% within Technical results	36.3%	33.5%
	Neither agree nor disagree	Count	17	67
		% within Technical results	10.6%	19.7%
	Disagree	Count	8	43
		% within Technical results	5.0%	12.6%
	Strongly disagree	Count	1	6
		% within Technical results	.6%	1.8%
Total		Count	160	340
		% within Technical results	100%	100%

Directional Measures

			Value	Asymp. Std. Error[a]
Ordinal by Ordinal	Somers' d	Symmetric	-.373	.041
		Costs of providing pod surg better spent on other health care Dependent	-.410	.046
		Technical results Dependent	-.342	.037

Crosstabulation 21

Case Processing Summary

	Cases	
	Valid	
	N	Percent
Increasing pod surg in NHS would increase patient satisfaction * Technical results	341	52.4%

Case Processing Summary

	Cases			
	Missing		Total	
	N	Percent	N	Percent
Increasing pod surg in NHS would increase patient satisfaction * Technical results	310	47.6%	651	100.0%

Increasing pod surg in NHS would increase patient satisfaction * Technical results Crosstabulation

Count

		Technical results			
		mainly satisfactory	neither	mainly unsatisfactory	Total
Increasing pod surg in NHS would increase patient satisfaction	Strongly agree	4	0	0	4
	Agree	32	3	4	39
	Neither agree nor disagree	52	17	26	95
	Disagree	37	21	71	129
	Strongly disagree	7	7	60	74
Total		132	48	161	341

Directional Measures

			Value	Asymp. Std. Error[a]
Ordinal by Ordinal	Somers' d	Symmetric	.451	.037
		Increasing pod surg in NHS would increase patient satisfaction Dependent	.492	.043
		Technical results Dependent	.416	.034

Case Processing Summary

	Cases		
	Valid		
	N	Percent	
Increasing pod surg in NHS would increase ortho surg caseload * Technical results	340	52.2%	

Case Processing Summary

	Cases			
	Missing		Total	
	N	Percent	N	Percent
Increasing pod surg in NHS would increase ortho surg caseload * Technical results	311	47.8%	651	100.0%

Increasing pod surg in NHS would increase ortho surg caseload * Technical results Crosstabulation

			Technical results			
			mainly satisfactory	neither	mainly unsatisfactory	Total
Increasing pod surg in NHS would increase ortho surg caseload	Strongly agree	Count	2	4	51	57
		% within Technical results	1.5%	8.3%	31.9%	16.8%
	Agree	Count	32	18	58	108
		% within Technical results	24.2%	37.5%	36.3%	31.8%
	Neither agree nor disagree	Count	37	20	36	93
		% within Technical results	28.0%	41.7%	22.5%	27.4%
	Disagree	Count	54	6	14	74
		% within Technical results	40.9%	12.5%	8.8%	21.8%
	Strongly disagree	Count	7	0	1	8
		% within Technical results	5.3%	.0%	.6%	2.4%
Total		Count	132	48	160	340
		% within Technical results	100%	100%	100%	100%

Directional Measures

			Value	Asymp. Std. Error[a]
Ordinal by Ordinal	Somers' d	Symmetric	-.430	.039
		Increasing pod surg in NHS would increase ortho surg caseload Dependent	-.480	.045
		Technical results Dependent	-.390	.034

Case Processing Summary

	Cases		
	Valid		
	N	Percent	
Increasing pod surg in NHS would result in financial savings for NHS * Technical results	342	52.5%	

Case Processing Summary

	Cases			
	Missing		Total	
	N	Percent	N	Percent
Increasing pod surg in NHS would result in financial savings for NHS * Technical results	309	47.5%	651	100.0%

Increasing pod surg in NHS would result in financial savings for NHS * Technical results Crosstabulation

			Technical	
			mainly satisfactory	neither
Increasing pod surg in NHS would result in financial savings for NHS	Strongly agree	Count	2	0
		% within Technical results	1.5%	.0%
	Agree	Count	21	1
		% within Technical results	15.9%	2.1%
	Neither agree nor disagree	Count	54	17
		% within Technical results	40.9%	35.4%
	Disagree	Count	47	21
		% within Technical results	35.6%	43.8%
	Strongly disagree	Count	8	9
		% within Technical results	6.1%	18.8%
Total		Count	132	48
		% within Technical results	100%	100%

Increasing pod surg in NHS would result in financial savings for NHS * Technical results Crosstabulation

			Techn mainly unsatisfactory	Total
Increasing pod surg in NHS would result in financial savings for NHS	Strongly agree	Count	0	2
		% within Technical results	.0%	.6%
	Agree	Count	7	29
		% within Technical results	4.3%	8.5%
	Neither agree nor disagree	Count	27	98
		% within Technical results	16.7%	28.7%
	Disagree	Count	73	141
		% within Technical results	45.1%	41.2%
	Strongly disagree	Count	55	72
		% within Technical results	34.0%	21.1%
Total		Count	162	342
		% within Technical results	100%	100%

Directional Measures

			Value	Asymp. Std. Error[a]
Ordinal by Ordinal	Somers' d	Symmetric	.363	.042
		Increasing pod surg in NHS would result in financial savings for NHS Dependent	.390	.046
		Technical results Dependent	.340	.038

Case Processing Summary

	Cases	
	Valid	
	N	Percent
Technical results * Pod surgs. should not practise because not medically qualified	336	51.6%

Case Processing Summary

	Cases			
	Missing		Total	
	N	Percent	N	Percent
Technical results * Pod surgs. should not practise because not medically qualified	315	48.4%	651	100.0%

Technical results * Pod surgs. should not practise because not medically qualified Crosstabulation

Count

		Pod surgs. should not practise because not medically qualified					
		Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Total
Technical results	mainly satisfactory	8	22	20	73	6	129
	neither	12	11	10	13	2	48
	mainly unsatisfactory	69	41	17	32	0	159
Total		89	74	47	118	8	336

Directional Measures

			Value	Asymp. Std. Error[a]
Ordinal by Ordinal	Somers' d	Symmetric	-.408	.040
		Technical results Dependent	-.373	.036
		Pod surgs. should not practise because not medically qualified Dependent	-.452	.044

Case Processing Summary

	Cases		
	Valid		
	N	Percent	
Pod surgs accept scope and limitations of their work * Technical results	340	52.2%	

Case Processing Summary

	Cases			
	Missing		Total	
	N	Percent	N	Percent
Pod surgs accept scope and limitations of their work * Technical results	311	47.8%	651	100.0%

Pod surgs accept scope and limitations of their work * Technical results Crosstabulation

			Technical results			
			mainly satisfactory	neither	mainly unsatisfactory	Total
Pod surgs accept scope and limitations of their work	Strongly agree	Count	11	7	24	42
		% within Technical results	8.3%	14.6%	15.0%	12.4%
	Agree	Count	68	11	27	106
		% within Technical results	51.5%	22.9%	16.9%	31.2%
	Neither agree nor disagree	Count	21	14	20	55
		% within Technical results	15.9%	29.2%	12.5%	16.2%
	Disagree	Count	31	14	52	97
		% within Technical results	23.5%	29.2%	32.5%	28.5%
	Strongly disagree	Count	1	2	37	40
		% within Technical results	.8%	4.2%	23.1%	11.8%
Total		Count	132	48	160	340
		% within Technical results	100%	100%	100%	100%

Directional Measures

			Value	Asymp. Std. Error[a]
Ordinal by Ordinal	Somers' d	Symmetric	.242	.045
		Pod surgs accept scope and limitations of their work Dependent	.273	.051
		Technical results Dependent	.217	.041

Case Processing Summary

	Cases	
	Valid	
	N	Percent
Pod surgs should only practise under guidance of ortho sug. * Technical results	338	51.9%

Case Processing Summary

	Cases			
	Missing		Total	
	N	Percent	N	Percent
Pod surgs should only practise under guidance of ortho sug. * Technical results	313	48.1%	651	100.0%

Pod surgs should only practise under guidance of ortho sug. * Technical results Crosstabulation

Count

		Technical results			
		mainly satisfactory	neither	mainly unsatisfactory	Total
Pod surgs should only practise under guidance of ortho sug.	Strongly agree	20	12	41	73
	Agree	33	13	50	96
	Neither agree nor disagree	34	13	29	76
	Disagree	42	8	21	71
	Strongly disagree	3	1	18	22
Total		132	47	159	338

Directional Measures

			Value	Asymp. Std. Error[a]
Ordinal by Ordinal	Somers' d	Symmetric	-.109	.047
		Pod surgs should only practise under guidance of ortho sug. Dependent	-.124	.053
		Technical results Dependent	-.097	.042

Case Processing Summary

	Cases	
	Valid	
	N	Percent
Pod surgs are suitably qualified and trained for work undertaken * Technical results	341	52.4%

Case Processing Summary

	Cases			
	Missing		Total	
	N	Percent	N	Percent
Pod surgs are suitably qualified and trained for work undertaken * Technical results	310	47.6%	651	100.0%

Pod surgs are suitably qualified and trained for work undertaken * Technical results Crosstabulation

Count

		Technical results			
		mainly satisfactory	neither	mainly unsatisfactory	Total
Pod surgs are suitably qualified and trained for work undertaken	Strongly agree	12	3	1	16
	Agree	47	5	15	67
	Neither agree nor disagree	47	18	29	94
	Disagree	24	16	61	101
	Strongly disagree	2	6	55	63
Total		132	48	161	341

Directional Measures

			Value	Asymp. Std. Error[a]
Ordinal by Ordinal	Somers' d	Symmetric	.460	.036
		Pod surgs are suitably qualified and trained for work undertaken Dependent	.519	.042
		Technical results Dependent	.414	.032

Case Processing Summary

	Cases		
	Valid		
	N	Percent	
Increasing pod surg in NHS would decrease ortho waiting lists * Patient satisfaction	336	51.6%	

Case Processing Summary

	Cases			
	Missing		Total	
	N	Percent	N	Percent
Increasing pod surg in NHS would decrease ortho waiting lists * Patient satisfaction	315	48.4%	651	100.0%

Increasing pod surg in NHS would decrease ortho waiting lists * Patient satisfaction Crosstabulation

			Patient satisfaction			
			mainly satisfactory	neither	mainly unsatisfactory	Total
Increasing pod surg in NHS would decrease ortho waiting lists	Strongly agree	Count	10	1	1	12
		% within Patient satisfaction	7.6%	2.1%	.6%	3.6%
	Agree	Count	51	10	26	87
		% within Patient satisfaction	38.6%	21.3%	16.6%	25.9%
	Neither agree nor disagree	Count	32	12	24	68
		% within Patient satisfaction	24.2%	25.5%	15.3%	20.2%
	Disagree	Count	34	17	62	113
		% within Patient satisfaction	25.8%	36.2%	39.5%	33.6%
	Strongly disagree	Count	5	7	44	56
		% within Patient satisfaction	3.8%	14.9%	28.0%	16.7%
Total		Count	132	47	157	336
		% within Patient satisfaction	100%	100%	100%	100%

Directional Measures

			Value	Asymp. Std. Error[a]
Ordinal by Ordinal	Somers' d	Symmetric	.346	.041
		Increasing pod surg in NHS would decrease ortho waiting lists Dependent	.387	.047
		Patient satisfaction Dependent	.313	.037

Crosstabulation 29

Appendix 51

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Costs of providing pod surg better spent on other health care * Patient satisfaction	335	51.5%	316	48.5%	651	100.0%

Costs of providing pod surg better spent on other health care * Patient satisfaction Crosstabulation

			Patient satisfaction			Total
			mainly satisfactory	neither	mainly unsatisfactory	
Costs of providing pod surg better spent on other health care	Strongly agree	Count	18	15	75	108
		% within Patient satisfaction	13.6%	31.9%	48.1%	32.2%
	Agree	Count	38	19	55	112
		% within Patient satisfaction	28.8%	40.4%	35.3%	33.4%
	Neither agree nor disagree	Count	40	8	19	67
		% within Patient satisfaction	30.3%	17.0%	12.2%	20.0%
	Disagree	Count	31	4	7	42
		% within Patient satisfaction	23.5%	8.5%	4.5%	12.5%
	Strongly disagree	Count	5	1	0	6
		% within Patient satisfaction	3.8%	2.1%	.0%	1.8%
Total		Count	132	47	156	335
		% within Patient satisfaction	100%	100%	100%	100%

Directional Measures

			Value	Asymp. Std. Error[a]	Approx. T[b]	Approx. Sig.
Ordinal by Ordinal	Somers' d	Symmetric	-.382	.041	-9.266	.000
		Costs of providing pod surg better spent on other health care Dependent	-.420	.046	-9.266	.000
		Patient satisfaction Dependent	-.351	.037	-9.266	.000

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

Crosstabulation 30

Case Processing Summary

	Cases		
	Valid		
	N	Percent	
Increasing pod surg in NHS would increase patient satisfaction * Patient satisfaction	336	51.6%	

Case Processing Summary

	Cases			
	Missing		Total	
	N	Percent	N	Percent
Increasing pod surg in NHS would increase patient satisfaction * Patient satisfaction	315	48.4%	651	100.0%

Increasing pod surg in NHS would increase patient satisfaction * Patient satisfaction Crosstabulation

Count

		Patient satisfaction			
		mainly satisfactory	neither	mainly unsatisfactory	Total
Increasing pod surg in NHS would increase patient satisfaction	Strongly agree	4	0	0	4
	Agree	32	3	5	40
	Neither agree nor disagree	52	18	23	93
	Disagree	36	18	73	127
	Strongly disagree	8	8	56	72
Total		132	47	157	336

Directional Measures

			Value	Asymp. Std. Error[a]
Ordinal by Ordinal	Somers' d	Symmetric	.441	.038
		Increasing pod surg in NHS would increase patient satisfaction Dependent	.482	.044
		Patient satisfaction Dependent	.407	.034

Crosstabulation 31

Case Processing Summary

	Cases	
	Valid	
	N	Percent
Increasing pod surg in NHS would increase ortho surg caseload * Patient satisfaction	335	51.5%

Case Processing Summary

	Cases			
	Missing		Total	
	N	Percent	N	Percent
Increasing pod surg in NHS would increase ortho surg caseload * Patient satisfaction	316	48.5%	651	100.0%

Increasing pod surg in NHS would increase ortho surg caseload * Patient satisfaction Crosstabulation

			Patient satisfaction			
			mainly satisfactory	neither	mainly unsatisfactory	Total
Increasing pod surg in NHS would increase ortho surg caseload	Strongly agree	Count	3	6	46	55
		% within Patient satisfaction	2.3%	12.8%	29.5%	16.4%
	Agree	Count	33	14	61	108
		% within Patient satisfaction	25.0%	29.8%	39.1%	32.2%
	Neither agree nor disagree	Count	39	19	32	90
		% within Patient satisfaction	29.5%	40.4%	20.5%	26.9%
	Disagree	Count	50	8	16	74
		% within Patient satisfaction	37.9%	17.0%	10.3%	22.1%
	Strongly disagree	Count	7	0	1	8
		% within Patient satisfaction	5.3%	.0%	.6%	2.4%
Total		Count	132	47	156	335
		% within Patient satisfaction	100%	100%	100%	100%

Directional Measures

			Value	Asymp. Std. Error[a]
Ordinal by Ordinal	Somers' d	Symmetric	-.397	.040
		Increasing pod surg in NHS would increase ortho surg caseload Dependent	-.443	.046
		Patient satisfaction Dependent	-.360	.036

Case Processing Summary

	Cases		
	Valid		
	N	Percent	
Increasing pod surg in NHS would result in financial savings for NHS * Patient satisfaction	337	51.8%	

Case Processing Summary

	Cases			
	Missing		Total	
	N	Percent	N	Percent
Increasing pod surg in NHS would result in financial savings for NHS * Patient satisfaction	314	48.2%	651	100.0%

Increasing pod surg in NHS would result in financial savings for NHS * Patient satisfaction Crosstabulation

			Patient	
			mainly satisfactory	neither
Increasing pod surg in NHS would result in financial savings for NHS	Strongly agree	Count	2	0
		% within Patient satisfaction	1.5%	.0%
	Agree	Count	20	1
		% within Patient satisfaction	15.2%	2.1%
	Neither agree nor disagree	Count	51	16
		% within Patient satisfaction	38.6%	34.0%
	Disagree	Count	49	19
		% within Patient satisfaction	37.1%	40.4%
	Strongly disagree	Count	10	11
		% within Patient satisfaction	7.6%	23.4%
Total		Count	132	47
		% within Patient satisfaction	100%	100%

Increasing pod surg in NHS would result in financial savings for NHS * Patient satisfaction Crosstabulation

			Patien mainly unsatisfactory	Total
Increasing pod surg in NHS would result in financial savings for NHS	Strongly agree	Count	0	2
		% within Patient satisfaction	.0%	.6%
	Agree	Count	8	29
		% within Patient satisfaction	5.1%	8.6%
	Neither agree nor disagree	Count	28	95
		% within Patient satisfaction	17.7%	28.2%
	Disagree	Count	74	142
		% within Patient satisfaction	46.8%	42.1%
	Strongly disagree	Count	48	69
		% within Patient satisfaction	30.4%	20.5%
Total		Count	158	337
		% within Patient satisfaction	100%	100%

Directional Measures

			Value	Asymp. Std. Error[a]
Ordinal by Ordinal	Somers' d	Symmetric	.310	.043
		Increasing pod surg in NHS would result in financial savings for NHS Dependent	.332	.047
		Patient satisfaction Dependent	.291	.040

Crosstabulation 33

Appendix 54a

Case Processing Summary

	Cases		
	Valid		
	N	Percent	
Pod surgs. should not practise because not medically qualified * Patient satisfaction	331	50.8%	

Case Processing Summary

	Cases			
	Missing		Total	
	N	Percent	N	Percent
Pod surgs. should not practise because not medically qualified * Patient satisfaction	320	49.2%	651	100.0%

Pod surgs. should not practise because not medically qualified * Patient satisfaction Crosstabulation

Count

		Patient satisfaction			
		mainly satisfactory	neither	mainly unsatisfactory	Total
Pod surgs. should not practise because not medically qualified	Strongly agree	13	12	61	86
	Agree	22	8	42	72
	Neither agree nor disagree	19	8	19	46
	Disagree	71	18	30	119
	Strongly disagree	6	2	0	8
Total		131	48	152	331

Directional Measures

			Value	Asymp. Std. Error[a]
Ordinal by Ordinal	Somers' d	Symmetric	-.364	.041
		Pod surgs. should not practise because not medically qualified Dependent	-.401	.046
		Patient satisfaction Dependent	-.333	.038

Case Processing Summary

	Cases	
	Valid	
	N	Percent
Pod surgs accept scope and limitations of their work * Patient satisfaction	335	51.5%

Case Processing Summary

	Cases			
	Missing		Total	
	N	Percent	N	Percent
Pod surgs accept scope and limitations of their work * Patient satisfaction	316	48.5%	651	100.0%

Pod surgs accept scope and limitations of their work * Patient satisfaction Crosstabulation

			Patient satisfaction			Total
			mainly satisfactory	neither	mainly unsatisfactory	
Pod surgs accept scope and limitations of their work	Strongly agree	Count	10	6	26	42
		% within Patient satisfaction	7.6%	12.8%	16.7%	12.5%
	Agree	Count	67	13	26	106
		% within Patient satisfaction	50.8%	27.7%	16.7%	31.6%
	Neither agree nor disagree	Count	23	10	21	54
		% within Patient satisfaction	17.4%	21.3%	13.5%	16.1%
	Disagree	Count	28	14	54	96
		% within Patient satisfaction	21.2%	29.8%	34.6%	28.7%
	Strongly disagree	Count	4	4	29	37
		% within Patient satisfaction	3.0%	8.5%	18.6%	11.0%
Total		Count	132	47	156	335
		% within Patient satisfaction	100%	100%	100%	100%

Directional Measures

			Value	Asymp. Std. Error[a]
Ordinal by Ordinal	Somers' d	Symmetric	.194	.046
		Pod surgs accept scope and limitations of their work Dependent	.219	.052
		Patient satisfaction Dependent	.174	.042

Case Processing Summary

	Cases		
	Valid		
	N	Percent	
Patient satisfaction * Pod surgs should only practise under guidance of ortho sug.	333	51.2%	

Case Processing Summary

	Cases			
	Missing		Total	
	N	Percent	N	Percent
Patient satisfaction * Pod surgs should only practise under guidance of ortho sug.	318	48.8%	651	100.0%

Patient satisfaction * Pod surgs should only practise under guidance of ortho sug. Crosstabulation

Count

		Pod surgs should only practise under guidance of ortho sug.					
		Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Total
Patient satisfaction	mainly satisfactory	22	34	32	40	4	132
	neither	9	13	14	9	1	46
	mainly unsatisfactory	40	48	29	22	16	155
Total		71	95	75	71	21	333

Directional Measures

			Value	Asymp. Std. Error[a]
Ordinal by Ordinal	Somers' d	Symmetric	-.098	.048
		Patient satisfaction Dependent	-.087	.043
		Pod surgs should only practise under guidance of ortho sug. Dependent	-.111	.054

Crosstabulation 36

Case Processing Summary

	Cases		
	Valid		
	N	Percent	
Patient satisfaction * Pod surgs are suitably qualified and trained for work undertaken	336	51.6%	

Case Processing Summary

	Cases			
	Missing		Total	
	N	Percent	N	Percent
Patient satisfaction * Pod surgs are suitably qualified and trained for work undertaken	315	48.4%	651	100.0%

Patient satisfaction * Pod surgs are suitably qualified and trained for work undertaken Crosstabulation

Count

		Pod surgs are suitably qualified and trained for work undertaken					
		Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Total
Patient satisfaction	mainly satisfactory	11	46	44	27	4	132
	neither	3	8	16	14	6	47
	mainly unsatisfactory	2	13	33	58	51	157
Total		16	67	93	99	61	336

Directional Measures

			Value	Asymp. Std. Error[a]
Ordinal by Ordinal	Somers' d	Symmetric	.417	.038
		Patient satisfaction Dependent	.375	.034
		Pod surgs are suitably qualified and trained for work undertaken Dependent	.469	.044

Gender of podiatric surgeons

Appendix 58

Statistics

gender

N	Valid	100
	Missing	0
Mode		1.00

gender

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	male	77	77.0	77.0	77.0
	female	23	23.0	23.0	100.0
	Total	100	100.0	100.0	

Ages of podiatric surgeons

Statistics

age

N	Valid	97
	Missing	3
Mean		45.8454
Range		46.00

age

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	31.00	1	1.0	1.0	1.0
	33.00	3	3.0	3.1	4.1
	35.00	2	2.0	2.1	6.2
	36.00	4	4.0	4.1	10.3
	37.00	6	6.0	6.2	16.5
	38.00	7	7.0	7.2	23.7
	39.00	4	4.0	4.1	27.8
	40.00	9	9.0	9.3	37.1
	41.00	6	6.0	6.2	43.3
	42.00	6	6.0	6.2	49.5
	43.00	5	5.0	5.2	54.6
	44.00	2	2.0	2.1	56.7
	45.00	2	2.0	2.1	58.8
	47.00	4	4.0	4.1	62.9
	48.00	3	3.0	3.1	66.0
	49.00	4	4.0	4.1	70.1
	50.00	2	2.0	2.1	72.2
	51.00	1	1.0	1.0	73.2
	52.00	3	3.0	3.1	76.3
	53.00	1	1.0	1.0	77.3
	54.00	1	1.0	1.0	78.4
	55.00	3	3.0	3.1	81.4
	56.00	5	5.0	5.2	86.6
	57.00	2	2.0	2.1	88.7
	58.00	1	1.0	1.0	89.7
	59.00	1	1.0	1.0	90.7
	60.00	4	4.0	4.1	94.8
	64.00	1	1.0	1.0	95.9
	65.00	1	1.0	1.0	96.9
	70.00	1	1.0	1.0	97.9
	74.00	1	1.0	1.0	99.0
	77.00	1	1.0	1.0	100.0
	Total	97	97.0	100.0	
Missing	System	3	3.0		
Total		100	100.0		

Pod. surgeons experience of ortho. contact Appendix 60

Statistics

In course of practice, experienced any form of professional contact with orthopaedic surgery?

N	Valid	100
	Missing	0

In course of practice, experienced any form of professional contact with orthopaedic surgery?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	yes	90	90.0	90.0	90.0
	no	10	10.0	10.0	100.0
	Total	100	100.0	100.0	

Pod. surgs. operating sessions per month Appendix 61

Statistics

typical month, number of surgery sessions held

N	Valid	100
	Missing	0
Mode		1.00

typical month, number of surgery sessions held

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1-7	41	41.0	41.0	41.0
	8-14	29	29.0	29.0	70.0
	15-21	14	14.0	14.0	84.0
	22 or more	6	6.0	6.0	90.0
	0	10	10.0	10.0	100.0
	Total	100	100.0	100.0	

Nature of contact with ortho. surgs.

Statistics

has this professional contact been:

N	Valid	90
	Missing	10
Mode		2.00

has this professional contact been:

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	very satisfactory	13	13.0	14.4	14.4
	satisfactory	33	33.0	36.7	51.1
	unsure	29	29.0	32.2	83.3
	unsatisfactory	12	12.0	13.3	96.7
	very unsatisfactory	3	3.0	3.3	100.0
	Total	90	90.0	100.0	
Missing	System	10	10.0		
Total		100	100.0		

Satisfactory contact with ortho. surgs. Appendix 63

Case Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
$mrnosc[a]	62	62.0%	38	38.0%	100	100.0%

a. Group

$mrnosc Frequencies

		Responses		Percent of Cases
		N	Percent	
nature of satisfactory contact[a]	integrated service	15	19.2%	24.2%
	joint consultation	14	17.9%	22.6%
	reciprocal referrals	15	19.2%	24.2%
	referrals	7	9.0%	11.3%
	generally supportive	18	23.1%	29.0%
	positive communication	7	9.0%	11.3%
	reciprocal training	2	2.6%	3.2%
Total		78	100.0%	125.8%

a. Group

Strategies to overcome unsat. contact

Case Summary

	Cases	
	Valid	
	N	Percent
$mrstrategies[a]	28	28.0%

Case Summary

	Cases			
	Missing		Total	
	N	Percent	N	Percent
$mrstrategies[a]	72	72.0%	100	100.0%

a. Group

$mrstrategies Frequencies

		Responses		Percent of Cases
		N	Percent	
Strategies[a]	appeal to management	7	14.3%	25.0%
	maintain professionalism	10	20.4%	35.7%
	confrontation	4	8.2%	14.3%
	attempt greater communication	13	26.5%	46.4%
	develop other resources	4	8.2%	14.3%
	change attitudes through evidence of successful work	8	16.3%	28.6%
	offers of assistance	1	2.0%	3.6%
	decrease scope of practice	2	4.1%	7.1%
Total		49	100.0%	175.0%

a. Group

Statistics

would the establishment of a more formal working relationship between podiatric and orthopaedic surgeons be:

N	Valid	98
	Missing	2
Mode		2.00

would the establishment of a more formal working relationship between podiatric and orthopaedic surgeons be:

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	very desirable	33	33.0	33.7	33.7
	desirable	52	52.0	53.1	86.7
	unsure	10	10.0	10.2	96.9
	undesirable	2	2.0	2.0	99.0
	very undesirable	1	1.0	1.0	100.0
	Total	98	98.0	100.0	
Missing	missing	2	2.0		
Total		100	100.0		

Working under ortho. direction

Statistics

If the opportunity arose would you consider working under the direction of orthopaedics in a dedicated foot-care team?

N	Valid	100
	Missing	0
Mode		4.00

If the opportunity arose would you consider working under the direction of orthopaedics in a dedicated foot-care team?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	yes	10	10.0	10.0	10.0
	maybe	24	24.0	24.0	34.0
	unsure	9	9.0	9.0	43.0
	no	57	57.0	57.0	100.0
	Total	100	100.0	100.0	

Further comment re formal assoc. with orthos. Appendix 67

Case Summary

	Cases	
	Valid	
	N	Percent
$mrfurthercomments[a]	100	100.0%

Case Summary

	Cases			
	Missing		Total	
	N	Percent	N	Percent
$mrfurthercomments[a]	0	.0%	100	100.0%

a. Group

$mrfurthercomments Frequencies

		Responses		Percent of Cases
		N	Percent	
Further comments[a]	cooperation would lead to greater workload	2	1.9%	2.0%
	secondment to other faculties would inc mutual understanding	1	1.0%	1.0%
	inter-professional conflict disguised as public protection	1	1.0%	1.0%
	none	93	90.3%	93.0%
	ortho-protectionism and self interest	2	1.9%	2.0%
	orthos against p.p. competition	2	1.9%	2.0%
	need to protect status as profession	2	1.9%	2.0%
Total		103	100.0%	103.0%

a. Group

Reasons for views on a more formal relationship. Appendix 68

Case Summary

	Cases	
	Valid	
	N	Percent
$msreasons2[a]	93	93.0%

Case Summary

	Cases			
	Missing		Total	
	N	Percent	N	Percent
$msreasons2[a]	7	7.0%	100	100.0%

a. Group

$msreasons2 Frequencies

		Responses		Percent of Cases
		N	Percent	
Reasons for answer 2[a]	partnership but not subservience	44	41.1%	47.3%
	expansion of knowledge	3	2.8%	3.2%
	against subservience	33	30.8%	35.5%
	best possible patient care	5	4.7%	5.4%
	unnecessary	3	2.8%	3.2%
	mutually advantageous	6	5.6%	6.5%
	avoids isolation	3	2.8%	3.2%
	increase employment opportunities	2	1.9%	2.2%
	better integration into NHS	2	1.9%	2.2%
	maintains medical dominance	4	3.7%	4.3%
	reduction in scope of practice	2	1.9%	2.2%
Total		107	100.0%	115.1%

a. Group

Unsatisfactory contact with ortho. surgs. Appendix 69

Case Summary

	Cases	
	Valid	
	N	Percent
$mrunsatisfactorycontact[a]	33	33.0%

Case Summary

	Cases			
	Missing		Total	
	N	Percent	N	Percent
$mrunsatisfactorycontact[a]	67	67.0%	100	100.0%

a. Group

$mrunsatisfactorycontact Frequencies

		Responses		Percent of Cases
		N	Percent	
Unsatisfactory contact[a]	obstruction to services	11	20.8%	33.3%
	unwillingness to interact	14	26.4%	42.4%
	suspicion/hostility	11	20.8%	33.3%
	complaints to management/purchasers	3	5.7%	9.1%
	misinformation to patients	5	9.4%	15.2%
	personally insulting	3	5.7%	9.1%
	incitement to litigation	6	11.3%	18.2%
Total		53	100.0%	160.6%

a. Group

Crosstabulation 37

Case Processing Summary

	Cases			
	Valid			
	N	Percent		
In course of practice, experienced any form of professional contact with orthopaedic surgery? * typical month, number of surgery sessions held	100	100.0%		

Case Processing Summary

	Cases			
	Missing		Total	
	N	Percent	N	Percent
In course of practice, experienced any form of professional contact with orthopaedic surgery? * typical month, number of surgery sessions held	0	.0%	100	100.0%

In course of practice, experienced any form of professional contact with orthopaedic surgery? * typical month, number of surgery sessions held Crosstabulation

			typical month, number of surgery sessions held		
			0	1-7	8-14
In course of practice, experienced any form of professional contact with orthopaedic surgery?	yes	Count	9	35	26
		% within In course of practice, experienced any form of professional contact with orthopaedic surgery?	10.0%	38.9%	28.9%
	no	Count	1	6	3
		% within In course of practice, experienced any form of professional contact with orthopaedic surgery?	10.0%	60.0%	30.0%
Total		Count	10	41	29
		% within In course of practice, experienced any form of professional contact with orthopaedic surgery?	10.0%	41.0%	29.0%

In course of practice, experienced any form of professional contact with orthopaedic surgery? * typical month, number of surgery sessions held Crosstabulation

			typical month, number of		
			15-21	22 +	Total
In course of practice, experienced any form of professional contact with orthopaedic surgery?	yes	Count	14	6	90
		% within In course of practice, experienced any form of professional contact with orthopaedic surgery?	15.6%	6.7%	100%
	no	Count	0	0	10
		% within In course of practice, experienced any form of professional contact with orthopaedic surgery?	.0%	.0%	100%
Total		Count	14	6	100
		% within In course of practice, experienced any form of professional contact with orthopaedic surgery?	14.0%	6.0%	100%

Directional Measures

			Value	Asymp. Std. Error[a]
Ordinal by Ordinal	Somers' d	Symmetric	-.103	.056
		In course of practice, experienced any form of professional contact with orthopaedic surgery? Dependent	-.065	.038
		typical month, number of surgery sessions held Dependent	-.257	.135

Crosstabulation 38

Case Processing Summary

	Cases		
	Valid		
	N	Percent	
has this professional contact been: * typical month, number of surgery sessions held	90	90.0%	

Case Processing Summary

	Cases			
	Missing		Total	
	N	Percent	N	Percent
has this professional contact been: * typical month, number of surgery sessions held	10	10.0%	100	100.0%

has this professional contact been: * typical month, number of surgery sessions held Crosstabulation

			typical month, number of surgery sessions held		
			0	1-7	8-14
has this professional contact been:	very satisfactory	Count	0	5	4
		% within typical month, number of surgery sessions held	.0%	14.3%	15.4%
	satisfactory	Count	4	12	10
		% within typical month, number of surgery sessions held	44.4%	34.3%	38.5%
	unsure	Count	4	10	9
		% within typical month, number of surgery sessions held	44.4%	28.6%	34.6%
	unsatisfactory	Count	1	6	3
		% within typical month, number of surgery sessions held	11.1%	17.1%	11.5%
	very unsatisfactory	Count	0	2	0
		% within typical month, number of surgery sessions held	.0%	5.7%	.0%
Total		Count	9	35	26
		% within typical month, number of surgery sessions held	100%	100%	100%

has this professional contact been: * typical month, number of surgery sessions held Crosstabulation

			typical month, number of		
			15-21	22 +	Total
has this professional contact been:	very satisfactory	Count	3	1	13
		% within typical month, number of surgery sessions held	21.4%	16.7%	14.4%
	satisfactory	Count	6	1	33
		% within typical month, number of surgery sessions held	42.9%	16.7%	36.7%
	unsure	Count	3	3	29
		% within typical month, number of surgery sessions held	21.4%	50.0%	32.2%
	unsatisfactory	Count	1	1	12
		% within typical month, number of surgery sessions held	7.1%	16.7%	13.3%
	very unsatisfactory	Count	1	0	3
		% within typical month, number of surgery sessions held	7.1%	.0%	3.3%
Total		Count	14	6	90
		% within typical month, number of surgery sessions held	100%	100%	100%

Directional Measures

			Value	Asymp. Std. Error[a]
Ordinal by Ordinal	Somers' d	Symmetric	-.077	.085
		has this professional contact been: Dependent	-.077	.085
		typical month, number of surgery sessions held Dependent	-.078	.085

Case Processing Summary

	Cases	
	Valid	
	N	Percent
if the opportunity arose would you consider working under the direction of orthopaedics in a dedicated foot-care team? * has this professional contact been:	90	90.0%

Case Processing Summary

	Cases			
	Missing		Total	
	N	Percent	N	Percent
if the opportunity arose would you consider working under the direction of orthopaedics in a dedicated foot-care team? * has this professional contact been:	10	10.0%	100	100.0%

if the opportunity arose would you consider working under the direction of orthopaedics in a dedicated foot-care team? * has this professional contact been: Crosstabulation

			has this professional		
			very satisfactory	satisfactory	unsure
if the opportunity arose would you consider working under the direction of orthopaedics in a dedicated foot-care team?	yes	Count	2	2	5
		% within has this professional contact been:	15.4%	6.1%	17.2%
	maybe	Count	6	12	4
		% within has this professional contact been:	46.2%	36.4%	13.8%
	unsure	Count	1	3	2
		% within has this professional contact been:	7.7%	9.1%	6.9%
	no	Count	4	16	18
		% within has this professional contact been:	30.8%	48.5%	62.1%
Total		Count	13	33	29
		% within has this professional contact been:	100%	100%	100%

if the opportunity arose would you consider working under the direction of orthopaedics in a dedicated foot-care team? * has this professional contact been: Crosstabulation

			has this		
			unsatisfactory	very unsatisfactory	Total
if the opportunity arose would you consider working under the direction of orthopaedics in a dedicated foot-care team?	yes	Count	0	0	9
		% within has this professional contact been:	.0%	.0%	10.0%
	maybe	Count	0	0	22
		% within has this professional contact been:	.0%	.0%	24.4%
	unsure	Count	1	0	7
		% within has this professional contact been:	8.3%	.0%	7.8%
	no	Count	11	3	52
		% within has this professional contact been:	91.7%	100%	57.8%
Total		Count	12	3	90
		% within has this professional contact been:	100%	100%	100%

Directional Measures

			Value	Asymp. Std. Error[a]
Ordinal by Ordinal	Somers' d	Symmetric	.299	.080
		if the opportunity arose would you consider working under the direction of orthopaedics in a dedicated foot-care team? Dependent	.272	.071
		has this professional contact been: Dependent	.332	.092

Case Processing Summary

	Cases		
	Valid		
	N	Percent	
has this professional contact been: * would the establishment of a more formal working relationship between podiatric and orthopaedic surgeons be:	87	87.0%	

Case Processing Summary

	Cases			
	Missing		Total	
	N	Percent	N	Percent
has this professional contact been: * would the establishment of a more formal working relationship between podiatric and orthopaedic surgeons be:	13	13.0%	100	100.0%

has this professional contact been: * would the establishment of a more formal working relationship between podiatric and orthopaedic surgeons be: Crosstabulation

Count

		would the establishment of a more formal working relationship between podiatric and orthopaedic surgeons be:					
		very desirable	desirable	unsure	undesirable	very undesirable	Total
has this professional contact been:	very satisfactory	9	1	1	0	0	11
	satisfactory	10	20	1	2	0	33
	unsure	1	7	1	0	0	9
	unsatisfactory	1	7	3	0	0	11
	very unsatisfactory	1	1	0	0	1	3
	satisfactory and unsatisfactory	10	8	2	0	0	20
Total		32	44	8	2	1	87

Directional Measures

			Value	Asymp. Std. Error[a]
Ordinal by Ordinal	Somers' d	Symmetric	.116	.103
		has this professional contact been: Dependent	.131	.117
		would the establishment of a more formal working relationship between podiatric and orthopaedic surgeons be: Dependent	.104	.092

Crosstabulation 41

Case Processing Summary

	Cases		
	Valid		
	N	Percent	
10 year bands * would the establishment of a more formal working relationship between podiatric and orthopaedic surgeons be:	95	95.0%	

Case Processing Summary

	Cases			
	Missing		Total	
	N	Percent	N	Percent
10 year bands * would the establishment of a more formal working relationship between podiatric and orthopaedic surgeons be:	5	5.0%	100	100.0%

10 year bands * would the establishment of a more formal working relationship between podiatric and orthopaedic surgeons be: Crosstabulation

Count

		would the establishment of a more formal working relationship between podiatric and orthopaedic surgeons be:					
		very desirable	desirable	unsure	undesirable	very undesirable	Total
10 year bands	1.00	7	14	2	1	1	25
	2.00	14	23	3	1	0	41
	3.00	8	9	3	0	0	20
	4.00	2	3	1	0	0	6
	5.00	1	2	0	0	0	3
Total		32	51	9	2	1	95

Directional Measures

			Value	Asymp. Std. Error[a]
Ordinal by Ordinal	Somers' d	Symmetric	-.067	.091
		10 year bands Dependent	-.073	.100
		would the establishment of a more formal working relationship between podiatric and orthopaedic surgeons be: Dependent	-.062	.085

Case Processing Summary

	Cases	
	Valid	
	N	Percent
if the opportunity arose would you consider working under the direction of orthopaedics in a dedicated foot-care team? * 10 year bands	97	97.0%

Case Processing Summary

	Cases			
	Missing		Total	
	N	Percent	N	Percent
if the opportunity arose would you consider working under the direction of orthopaedics in a dedicated foot-care team? * 10 year bands	3	3.0%	100	100.0%

if the opportunity arose would you consider working under the direction of orthopaedics in a dedicated foot-care team? * 10 year bands Crosstabulation

			10 year bands		
			1.00	2.00	3.00
if the opportunity arose would you consider working under the direction of orthopaedics in a dedicated foot-care team?	yes	Count	1	5	2
		% within 10 year bands	3.7%	12.2%	10.0%
	maybe	Count	7	9	7
		% within 10 year bands	25.9%	22.0%	35.0%
	unsure	Count	4	1	2
		% within 10 year bands	14.8%	2.4%	10.0%
	no	Count	15	26	9
		% within 10 year bands	55.6%	63.4%	45.0%
Total		Count	27	41	20
		% within 10 year bands	100%	100%	100%

if the opportunity arose would you consider working under the direction of orthopaedics in a dedicated foot-care team? * 10 year bands Crosstabulation

			10 year bands		
			4.00	5.00	Total
if the opportunity arose would you consider working under the direction of orthopaedics in a dedicated foot-care team?	yes	Count	1	1	10
		% within 10 year bands	16.7%	33.3%	10.3%
	maybe	Count	1	0	24
		% within 10 year bands	16.7%	.0%	24.7%
	unsure	Count	1	0	8
		% within 10 year bands	16.7%	.0%	8.2%
	no	Count	3	2	55
		% within 10 year bands	50.0%	66.7%	56.7%
Total		Count	6	3	97
		% within 10 year bands	100%	100%	100%

Directional Measures

			Value	Asymp. Std. Error[a]
Ordinal by Ordinal	Somers' d	Symmetric	-.073	.086
		if the opportunity arose would you consider working under the direction of orthopaedics in a dedicated foot-care team? Dependent	-.068	.080
		10 year bands Dependent	-.079	.093